Wisconsin Partnership Program

Protocol Manual
Part I - Site Operations

Revised: December 21, 2004

Wisconsin Department of Health and Family Services

Wisconsin Partnership Program Protocol:

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Purpose of this Document

The purpose of the Wisconsin Partnership Program Site Operations Protocol, hereinafter referred to as the Protocol, is to establish operational guidelines for Wisconsin Partnership Program (Partnership) sites to meet requirements of the Partnership/Medicaid contract and the waivers acquired from the Centers for Medicare and Medicaid Services. It is intended that the Protocol is a living document and that it constantly evolve as better clinical and long-term care practices emerge.

Mission and Principles

Mission

The mission of the Wisconsin Partnership Program is to provide an integrated model of health and social services maximizing the ability of members to live in the setting of their choice, participating in community life, and engaging in the decision-making processes regarding their own care. The Wisconsin Partnership Program ensures that members receive high quality health care, social services and other supports necessary to be valued citizens living in and giving to the community.

Principles

Partnership's guiding principles are to:

1. Deliver and coordinate health and long-term care through an interdisciplinary team.
2. Treat its members as dignified individuals who are accountable for their responsibilities and entitled to their rights.
3. Allow members to manage their own services to the greatest extent possible or to the extent they desire.
4. Offer members the information necessary to make informed decisions.
5. Deliver quality services that are both member and provider friendly, on a timely basis.
6. Educate health care professionals regarding the frail elderly and people with disabilities.
7. Maintain physical and mental health standards to assure optimal levels of health and functioning for members.
8. Encourage its members to develop and maintain friendships and participate with their families and in their communities.
9. Consider the changing needs of its members and to flexibly adapt services as necessary.
10. Emphasize member's self-reliance and sense of self worth
11. Carry out the member's service plan by utilizing effectively and equitably the available public and private resources.

Member Participation

The mission of the Wisconsin Partnership Program is to provide an integrated model of health and social services maximizing the ability of members to live in the setting of their choice, participating in community life, and engaging in the decision-making processes regarding their own care. The Wisconsin Partnership Program ensures that members receive high quality health care, social services and other supports necessary to be valued citizens living in and giving to the community.

The Partnership Program strives to maximize the role of the member in their care planning including the selection of time, place, setting of their care and service provider. The Partnership Program recognizes the rights and responsibilities that its members have as the recipients of integrated managed Medicare and Medicaid benefits, and the responsibilities of the Partnership Organization to facilitate the exercise of the member's rights, responsibilities, participation and choice.

The Wisconsin Partnership Program encourages member participation and choice through a variety of avenues that are incorporated throughout the Wisconsin Partnership Program Protocol as highlighted below.

1. Partnership Program Principles are used to guide member participation.

2. Member's input regarding marketing materials for cultural awareness and readability.

3. Members provide feedback for primary care physician reviews, the evaluation of the provider network and the Partnership Organization via surveys, interviews or focus groups.

4. Members have rights and responsibilities in Partnership.

5. Members may participate on grievance advisory committees.

6. Members may participate on QA/QI committees; sites use consumer-defined quality indicators.

7. Members will participate on the governing body and may participate on the Ethics Committee.

8. Members participate in their own assessments, service planning and delivery.

9. Members have opportunities to choose or request:

    a. Primary care physician
    b. Home care workers and other providers
    c. Care settings

Service Coverage

Provision of Services

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organizations are required by contract to provide or arrange for all Medicaid and Medicare covered services including nursing facility, primary and acute and long-term support services.

Operating Guidelines:

1. Services must be accessible to members in terms of timeliness, amount, duration and scope.

2. Services must be provided by Medicaid and Medicare certified providers except in cases where they do not exist or as specifically permitted by the Department.

3. The Partnership Organization will provide or arrange for integrated primary, acute and long-term care services through an interdisciplinary team comprised of a nurse practitioner, registered nurse, and social worker/social services coordinator.

4. Medically necessary services must be available 24 hours a day, seven days a week either through the Partnership Organization or with arrangements with other providers.

5. The member will have one, toll free phone number to call with problems 24 hours a day.

6. Outside of normal business hours the Partnership Organization will have a system in place to respond to member calls within an hour.

Service Summary

A. Outpatient Health Services

- General medical and specialist care including a woman's health specialist as requested.
- Nursing care.
- Social services.
- Prescribed medications and pharmacy services when prescribed by a Partnership physician or Partnership nurse practitioner and dispensed by a *[WPP Site Name]* contracted pharmacy using *[WPP Site Name]* preferred medication list.
- Physical, occupational, speech, and respiratory therapies.
- Laboratory tests, X-ray and other diagnostic tests.
- Vision care, including examinations and treatment.
- Hearing services, including evaluation, hearing aids, repairs, and regular care.
- Podiatry services, including routine foot care.
- Psychiatric care including evaluation, consultation, diagnosis, and treatment.
- Artificial limbs, disposable medical supplies, and durable medical equipment (such as hospital beds, wheelchairs, and walkers).
- Nutritional counseling and special diet assistance.
- Alcohol and other drug treatment.
- Chiropractic services.
- Family planning services.
- Prenatal care coordination.
- Dental Services including diagnostic services, preventive service, restorative dentistry, prosthetic appliances and oral surgery.

B. Inpatient Hospital Care

- Semi-private room and meals. *
- General medical and nursing services.
- Medical and surgical care, intensive care, and coronary care units as necessary.
- Laboratory tests, X-rays and other diagnostic procedures.
- Receiving blood or plasma.
- Prescribed drugs and medicine.
- Use of oxygen.
- Physical, occupational, speech, and respiratory therapies.
- Psychiatric care.
- Social services and planning for discharge from the hospital.
- Alcohol and other drug treatment.

C. Nursing Home Care

- Semi-private room and meals.*
- Doctor and nursing services.
- Custodial care.
- Personal care and assistance.
- Prescribed drugs and medicines.
- Physical, occupational, and speech therapies.
- Social services and planning for discharge.
- Medical supplies and appliances.

D. Other Health-Related and Community-Based Services

- Case management.
- Supportive Housing
- Home care including Home Health Aide, Personal Care Assistance and Chore Services.
- Respite care.
- Adult day healthcare.
- Home modifications.
- Transportation, medical and non-medical.
- Specialized medical equipment and supplies.
- Home delivered meals.
- Personal emergency response systems
- End of Life services including Hospice Services.

* Partnership will usually not pay for private rooms or private duty nurses. Partnership will pay for these extra services only if they have prior authorized and are medically necessary. Non-medical charges, such as telephone, radio or television rentals, are not paid for by Partnership.

Service Coverage
Emergency Services

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organization is required by contract to ensure that emergency services are available 24 hours a day, seven (7) days a week.

Definitions:

Emergency services are services for serious or life-threatening illnesses or injuries that must be obtained without delay by a member in order to avoid death or serious medical consequences such as lasting or permanent loss of body functions, organ damage, or other serious and lasting health impairments. Some examples of conditions typically requiring emergency treatment are:

Choking	Severe or unusual bleeding
Trouble breathing	Suspected poisoning
Serious broken bones	Suspected heart attack
Unconsciousness	Suspected stroke
Severe burns	Convulsions
Severe pain	Prolonged or repeated seizures

Operating Guidelines:

1. Prior authorization for treatment of an emergency medical condition is not required. The Partnership program will always pay for emergency services whether the member is in or out of the service area unless the medical problem is not a true emergency.

2. Payments for qualifying emergencies, including services at hospitals or urgent care centers within the service area(s), are to be based on the medical signs and symptoms of the condition upon initial presentation. The retrospective findings of a medical work-up may legitimately be the basis for determining how much additional care may be authorized, but not for payment for dealing with the initial emergency.

3. The Partnership Program organization must ensure that members are provided information on how to obtain emergency services on a 24-hour basis, 7 days a week. This is to include information regarding contacting the Partnership Organization, whether in or out of the service area, within 48 hours of receiving emergency services so that follow-up care can be managed. If notification by the member does not occur within 48 hours, the Partnership Organization is not obligated to cover the costs of follow-up care.

4. For emergency services furnished by an out of network provider, the Wisconsin Partnership Organizations will be responsible for the reasonable cost of emergency services. “Reasonable cost of emergency services” is defined under Federal Regulations. See 42 CFR §438.114(e).

Service Coverage

Urgent Care

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organization is required by contract to ensure that members have access to urgent care services during regular business hours of the Urgent Care Facility. The Emergency Room (ER) is used when Urgent Care is closed.

Definitions:

Urgent care is defined as care that is needed sooner than a routine visit to the doctor or nurse but it is not an emergency. Urgent care can be received in the member's home, doctor's office or at an Urgent Care Center. Some examples are:

Some broken bones	Minor cuts
Sprains	Bruises
Non-severe bleeding	Most medication reactions
Minor burns	

Operating Guidelines:

1. The Partnership Program organization must ensure that members are provided information on how to obtain urgent care services.

2. This information should include how to obtain in-area urgent care services, including any pre-authorization requirements for follow-up services.

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3. If the member is in the service area the member must contact the Partnership Organization team nurse or on call nurse to discuss the urgent care issue. The nurse and the member will decide how to handle the situation. If this contact is not made, the Partnership Organization is not obligated to pay for the urgent care or follow-up care.

4. If the member is out of the service area the member must call the Team nurse or On Call nurse within forty-eight (48) hours of receiving the urgent care services. If this contact is not made, the Partnership Organization is not obligated to pay for the cost of follow-up care.

Service Coverage

Excluded Services

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organization is required by contract to inform members that any care that is not authorized by the care team, exclusive of emergency care, urgent care or family planning services, may be considered as an excluded service.

Operating Guidelines:

The Wisconsin Partnership Organization is not required to provide the following services This is a partial list. This is not a complete list but are examples of services/items that may be excluded.

1. Any service that is not prior authorized by the Partnership Team (except for emergency services or out-of –area urgently needed services, family planning, women's health services and in some instances post stabilization services).

2. Prescription drugs not authorized by a Partnership physician or Nurse Practitioner including self-administered prescription medication for the treatment and/or surgery of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.

3. Cosmetic surgery unless it is determined by the member's care team to be medically necessary.

4. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.

5. Procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by the Partnership Organization.

6. Naturopath's services.

7. Nursing care on a full-time basis in the member's home.

8. Personal convenience items, such as telephone or television in a member's hospital room or skilled nursing facility.

9. Private duty nurses.

10. Private room in a hospital, unless medically necessary.

11. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. However, medically necessary services for infertility are covered.

12. Emergency facility services for non-authorized, routine conditions that do not appear to a prudent layperson to be based on an emergency medical condition.

13. Surgical treatment of morbid obesity unless determined Medically Necessary by a Partnership Organization Medical Director or designee.

14. Radial keratotomy and low vision aids and services.

15. Experimental or investigational medical and surgical procedures, equipment and medications, that are otherwise not covered by Medicare of Medicaid or covered under clinical trials.

16. Care in a governmental hospital (VA, federal, or state hospitals) unless approved by the Partnership Organization Team or there is a regulatory exception to this general exclusion.

17. Any routine medical services given outside of North America, which includes the United States, Canada, Mexico, and Puerto Rico.

Provider Network

Assurances and Standard Language

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organization is required by contract to provide the Department and CMS with adequate assurance that it has the capacity to serve the expected enrollment in the service area, that it offers an appropriate range of services and access to preventive and primary care services, and that it maintains a sufficient number, mix, and geographic distribution of providers of services. The Wisconsin Partnership Organization is also required by contract to assure that standard language is used in all subcontracts except for specific provisions that are inapplicable in a specific Partnership Organization management subcontract.

Operating Guideline:

All provisions of or subcontracting for Medicare and Medicaid services will be in accordance with Article V of the Partnership contract to which this protocol is appended. Additional provider network assurance provisions can be found in Articles II (two), IV (four) and X (ten) of the Partnership contract between the Wisconsin Partnership Organization and the Wisconsin Department of Health and Family Services Division of Disability and Elder Services.

Provider Network

Provider Qualifications

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program Organization is required by contract to provide the Department and CMS with assurance that both its staff and provider network are qualified to safely serve its members.

Definition:

Credential Verification is the review of licenses, diplomas, transcripts, certificates or other documentation of an individual's qualification to provide services.

1. For physicians and other licensed healthcare professionals, including members of physician groups, the process must verify current eligibility to participate in the Medicaid and Medicare programs.
2. For other care workers, such as personal care workers or specialized transportation providers, the process includes completion of any education or skills training necessary to provide specific services, and a criminal background check.

Operating Guidelines:

1. The Partnership Organization will verify, as described in the definition above, the qualifications of health professionals and other service workers under the Partnership Organization's direct employment.
    a. Credential verification may be conducted by Partnership staff or delegated to an accredited credentialing organization under contract to the Partnership Organization.
    b. Verification must be repeated on a regular, periodic basis, but no less frequently than every three years.
    c. The Partnership Organization must also evaluate the extent to which these workers meet its standards in their work.

2. The Partnership Organization will r*equire subcontractors* to verify qualifications of those health professionals and other service workers under the subcontractor's employment who serve Partnership clients. Subcontracts will specify the Partnership Organization's performance expectations.

    a. Under subcontracts, the other organization will be required to verify, as described in the definition above, the credentials of all workers providing services to Partnership members under the subcontract.
        i. Credential verification may be conducted by the subcontractor staff or delegated to an accredited credentialing organization under contract to the subcontract organization.

ii. Verification must be repeated on a regular, periodic basis, but no less frequently than every three years.

b. Subcontractors must allow the Partnership Organization to monitor credential verification by periodic review of the process, including random spot checks of documentation.
c. Subcontract renewal must be contingent on the subcontractor meeting the performance requirements of the Partnership Organization.

3. The Partnership Organization will provide the Department and CMS with a letter attesting to its performance with these requirements, and describing the direct or delegated procedures used.

Partnership Physician Arrangements

Medical Director

Wisconsin Partnership Program Protocol:

The Medical Director will oversee the systems that assure the quality and cost effectiveness of medical care within the Partnership Organization.

Operating Guidelines:

The Medical Director will:

1. Actively participate with the Partnership Organization's management in the expansion of the physician panel, particularly in the area of physician agreement with the program philosophy, Nurse Practitioner role and Utilization Management.

2. Oversee the primary care practice of the nurse practitioners.

3. Review and monitor the following with the team as appropriate:

    a. Nursing home admissions
    b. DME over $1,000
    c. Hospitalizations, inpatient, outpatient
    d. Emergency Room visits
    d. Specialists out of the network

4. Participate with the Nurse Practitioner as needed in concurrent review of member hospitalization.

5. In collaboration with the Partnership Organization management, conduct primary care physician performance reviews, which includes:

    a. Data from Utilization Review and Quality Assurance
    b. Member feedback
    c. Team feedback

6. Facilitate medical decision-making as needed with the team and primary care physician, particularly in situations requiring complex problem solving or conflict resolution.

Partnership Physician Arrangements

Physician Panel Development

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organization must designate a person within the organization who is responsible, in collaboration with the Medical Director, for all physician-related activities.

Operating Guidelines:

Each Partnership Organization will:

1. Develop and implement a plan for physician panel expansion as needed that allows for growth in enrollment capacity, reasonable accommodation of client preferences, and sound financial management.

2. Only contract with physicians (both primary and specialty) who are qualified to participate in the Medicaid and Medicare programs.

3. Only contract with physicians (both primary and specialty) who are board certified or eligible in their specialty, or otherwise verified as competent. If a physician is not board certified or eligible, the Partnership Organization may develop and document their own procedure to verify that the physician is otherwise qualified to participate.

4. Contract with physicians (both primary and specialty) on a fee for service basis or in a manner that meets the requirements of the Protocol: "Physician Incentive Plan."

5. Only contract with primary care physicians who agree to:

    a. The Partnership Program Philosophy
    b. Nurse Practitioner collaboration
    c. Participate in an interdisciplinary team
    d. Work collaboratively with the Partnership Organization's Medical Director
    e. Participate in the utilization management process
    f. Participate in the quality improvement process

6. Permit physicians to freely discuss treatment options with members. No restriction shall be placed on physician-patient communications within the program.

7. Patient Load. To preserve member choice of physician, no primary care physician may serve more than 50 members of a single Partnership Organization.

Partnership Physician Arrangements

Physician Provider Manual

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organization must ensure that each primary care physician has received the Physician Provider Manual.

Operating Guidelines:

It is suggested that the following elements be incorporated in the Physician Provider Manual:

1. Partnership Program Philosophy

    a. Physicians will treat Members as partners in the Member's own health care.
    b. Physicians will treat Members with respect.
    c. Physicians will adhere to the Wisconsin Partnership Program Mission and Principles.
    d. Physicians agree to provide services to Partnership members.

2. Nurse Practitioner Collaboration

    a. Physicians will sign a collaborative practice agreement with the nurse practitioner.
    b. Physicians will jointly manage the medical care of Partnership Members with the nurse practitioner.

3. Interdisciplinary Team--The team is responsible for integrating health and long-term care.

    a. Each member is assigned an interdisciplinary team, comprised of, at a minimum, a Nurse Practitioner, Registered Nurse and Social Worker/Social Services Coordinator. Responsibility for assessment, care planning, service authorization and delivery, coordination, monitoring, health education and prevention rests with the team.
    b. The Nurse Practitioner will serve as the primary liaison between the team, the member and the primary care physician to allow joint, shared team responsibilities in developing the service plan and providing needed services as decided by the team and member.
    c. Physicians will incorporate team input, including member input, regarding social and non-medical member issues into medical decisions as appropriate.
    d. Physicians will provide medical expertise to the team.

4. Medical Director--Physicians will work with the Medical Director as requested:

    a. To review the Partnership Program in order to refine and enhance the model.

b. To participate in the utilization review process.
c. To assure and improve the quality of care.

5. Utilization Management

a Physicians will participate in the utilization management processes requested by the Partnership Organization.
b. Primary care physicians must authorize all specialty referrals, diagnostic testing, and medical procedures.

6. Quality Improvement

a. Physicians will participate in the Partnership Organization's quality improvement process and ethics committee activities as requested by the Partnership Organization.

7. Grievance process and expedited grievance process.

8. Enrollment and disenrollment procedures.

9. Standards for member health maintenance, prevention, and screening.

10. Accessibility standards for:

a. Physical accessibility to the physician's office
b. Waiting and response times for routine, urgent and emergency member visits
c. Back-up and on-call procedures

11. Interdisciplinary care team description

12. Service ordering procedures for:

a. Physician specialty, sub-specialty, ancillary, and diagnostic services
b. Hospital admissions
c. Nursing facility admissions
d. Ordering durable medical equipment and supplies
e. Mental health and substance abuse
f. Outpatient mental health services

13. Billing procedures for physician services

14. Prior authorization procedures

15. Partnership Organization Physician Manuals may also include:

a. Partnership Organization-specific prior authorization requirements.

b. Other items as specified by the individual contractor that are not in conflict with required elements.

Partnership Physician Arrangements

Physician Contract

Wisconsin Partnership Program Protocol:

Wisconsin Partnership Organizations will have a signed contract with physicians or physician organizations that specifies the requirements for physician practice within their Partnership program.

Operating Guidelines:

1. Physician contracts will include:

    a. Provision for discharge of physicians that fail to adhere to elements defined in the Wisconsin Partnership Physician Provider Manual.
    b. Minimum standards for physician credential verification.
    c. The scope of physician services.
    d. Relationship with the Partnership Organization Medical Director.
    e. Prior authorization requirements.
    f. Standards for waiting and response times for routine, urgent and emergent client visits and 24 hour services coverage.
    g. Standards for physical accessibility.
    h. Standards for back-up and on-call procedures.
    i. Terms of physician fee-for-service compensation arrangements.
    j. Malpractice insurance requirements.
    k. A statement of independence and non-indemnification.
    l. A requirement for participation in quality, utilization management, and peer review.
    m. A requirement for collaboration with the nurse practitioner and interdisciplinary team.
    n. A requirement to maintain medical records.

2. Physician contracts may also include:

    a. Consumer-developed standards for physician interaction with members.
    b. Requirements for participation in various meetings.
    c. Standards for participation in continuing education.
    d. Other items as specified by the individual contractor that are not in conflict with required elements.

3. Physicians must maintain qualification to participate in the Medicare and Medicaid Program.

4. Physicians must maintain a current Wisconsin license.

5. Physicians must maintain registration with Drug Enforcement Administration.

Partnership Physician Arrangements

Model WPP Physician Contract

It is suggested that the following model contract may be used when developing the Physician Contract.

The Partnership Organization is part of the Wisconsin Partnership Program (WPP), a collaborative group of organizations serving both frail elderly and adult physically disabled people.

Enrollment is voluntary, and members may disenroll after one month.

To be eligible for service from a WPP organization, people must meet Wisconsin Medicaid criteria for nursing home level of care, and must be financially certified to receive Medicaid.

The Partnership Organization receives a monthly capitation payment from Medicaid for each member. The Partnership Organization also receives a monthly capitated payment from Medicare if the member is Medicare-eligible. In exchange, the Partnership Organization assumes responsibility and financial risk for the member's care.

Services are organized through an interdisciplinary team, which includes the WPP member, independent physician, staff Nurse Practitioner, staff nurse, and staff Social Worker/Social Services Coordinator. Physical therapists, occupational therapists and personal care workers are also key members in care, and provide important input for decision making. The interdisciplinary team collaborates to select and provide a broad spectrum of services tailored to the needs and preferences of the member, maximizing independent living to the greatest extent possible. The assurance of regular monitoring, reliable, consistent service delivery and enhanced understanding of member social supports and constraints helps the physician to optimally provide effective and humanistic medical care.

2. Physician Role
   The WPP Physician agrees to provide primary care to members.

   The physician role includes:

2.1 History and Physical Assessment
   Collaboration with the Partnership Organization Nurse Practitioner to obtain a complete medical history and physical and updates as needed.

2.2 Primary Care
   Treat and manage acute and chronic illness.

   Triage health status changes and facilitate appropriate treatment and follow-up.

Regulate medications, consulting with the Partnership Organization pharmacist as necessary.

Assure that each member receives appropriate preventive health screens, information and interventions, in accord with the WPP Protocol.

2.3 Member

Help to inform and educate each member and their family about the member's medical conditions, risks, prevention, and options for self-care and treatment without any restriction on communications by the Partnership Organization.

Learn member and family preferences for treatment options and advance directives.

Provide opportunities for the member to participate in medical decisions as a partner.

Inform members of their right to a second medical opinion.

2.4 Partnership Organization Medical Director

Collaborate to develop WPP clinical protocols in accord with WPP principles.

Consult with the Partnership Organization Medical Director as needed to resolve difficult medical decisions, especially when the interdisciplinary team fails to reach consensus.

2.5 Nurse Practitioner

Collaborate with the Partnership Organization Nurse Practitioner.

Communicate with the Nurse Practitioner in a timely fashion.

2.6 Partnership Organization Interdisciplinary Team

Collaborate with the Partnership Organization interdisciplinary team, acknowledging the expertise and contribution of each team member, and sharing discipline-appropriate responsibilities and tasks to reach common goals.

With the Partnership Organization interdisciplinary team, assure consideration of relevant non-medical factors in medical decision making.

Provide insight into relevant medical issues when the Partnership Organization interdisciplinary team makes non-medical decisions.

Consult with the Partnership Organization interdisciplinary team as necessary to assure the quality of delegated medical services.

2.7 Accessibility

Maintain a clinical office that is physically accessible to members.

Make a reasonable effort to deliver services in settings that promote member independence and choice.

Provide or direct care in such places and times as are practical, necessary and appropriate to accommodate member needs and service complexity.

Provide or direct routine, urgent, and emergent care within the waiting and response times specified in the Partnership Organization Physician Manual.

Assure appropriate twenty-four hour service coverage.

2.8 Specialist Consultation

Consult with specialists as needed to assure continuity of care, and consistency of care with WPP goals.

Use Partnership Organization approved specialists or obtain prior authorization from the Partnership Organization Medical Director for referrals to other specialists.

Authorize and control the quantity and nature of specialist visits, laboratory tests, diagnostic procedures, and treatments.

2.9 Prior Authorization

Consult with the Nurse Practitioner and jointly authorize use of the services requiring prior authorization, as described in the Partnership Organization provider manual.

Obtain prior authorization from the Partnership Organization Medical Director for procedures specified in the Partnership Organization Physician Manual, including:

Nursing home admission, referral to a specialist not approved by the Partnership Organization, and Durable Medical Equipment costing in excess of $1000.

Collaborate with the Nurse Practitioner to coordinate discharge planning with the interdisciplinary team.

3. Medical Records

The WPP Physician will maintain records documenting service to members in accord with Medicaid and Medicare standards.

4. Quality Management

The WPP Physician agrees to attend meetings with the Partnership Organization Medical Director and staff for the purpose of evaluating and improving the WPP care model.

The WPP Physician agrees to cooperate with Partnership Organization quality management initiatives.

4.1 Peer Review

The WPP Physician agrees to cooperate with any Partnership Organization peer review activities conducted by the Partnership Organization Medical Director and medical advisory group or the Wisconsin Peer Review Organization (WIPRO).

4.2 Standard Orders, and Protocols

The WPP Physician agrees to participate in the development and implementation of standard orders and treatment protocols to assure consistency and efficiency of care.

4.3 Staff Education

The WPP Physician agrees to assist in staff education when necessary to improve and assure the quality of services.

4.4 Research and Dissemination of Model

The WPP Physician acknowledges that, as a demonstration project, the Wisconsin Partnership Program is obligated to evaluate and publish information on its care model, and that the WPP Physician will cooperate with such efforts.

If the WPP Physician chooses to publish her or his own research relative to the Wisconsin Partnership Program, he or she will provide copies to the Partnership Organization Medical Director for review and commentary before publishing.

5. Utilization Management

The WPP Physician agrees to cooperate with Partnership Organization utilization management activities.

6. Independence

The relationship between the WPP Physician and the Wisconsin Partnership Program under this agreement is between independent contractors and for the sole purpose of carrying out the terms of this agreement. Nothing in this agreement will be construed to create a business partnership, joint venture, employer-employee or principal-agent relationship between the parties, nor will the parties present themselves as being a business partnership, joint venture, employer-employee or principal-agent relationship.

7. Liability

The WPP Physician and the Wisconsin Partnership Program understand that this agreement is not for one party to insure or indemnify the other, and each party will be responsible for its own acts, omission and negligence.

The WPP Physician (or his or her provider organization) will maintain malpractice insurance coverage.

8. Compensation

All additional compensation will be paid on a fee-for-service basis at rates negotiated with the Partnership Organization. The WPP Physician is in no way at risk for the cost of care provided to the member, so long as the Partnership Organization prior authorization procedures are followed.[NOTE: A Partnership Organization may compensate physicians

based upon a Physician Incentive Plan rather than a Fee For Service basis as long as the Physician Incentive Plan meets the requirements of the Protocol.
(See "Physician Incentive Plan".)

9. Credentials

9.1 Licensure

Each WPP Physician will maintain a Wisconsin license to practice.

The provider shall certify that staff under its employment that provides services to WPP members are duly licensed.

Each WPP Physician shall maintain registration with the Drug Enforcement Administration (DEA) and hold a valid DEA number for prescription purposes.

9.2 Medicare and Medicaid Qualification

The WPP Physician shall maintain qualification to provide care under the Medicare and Medicaid programs unless authorized, in writing, by the Department.

The WPP Physician shall certify that staff under his or her employment and serving members are qualified providers under the Medicare and Medicaid programs unless authorized, in writing, by the Department.

9.3 Verification

The WPP Physician authorizes the Partnership Organization to verify the validity of her or his credentials with appropriate licensure bodies, Medicare and Medicaid agencies, the National Practitioner Data Bank, hospitals, professional and specialty societies, continuing medical education providers, medical schools and other entities as appropriate.

10. Term and Termination

This agreement will be in place for one twelve month period beginning <month day year> and ending <month day year>.

This contract may not be assigned to another party.

Either party may terminate this agreement if the other party fails to meet any material condition of this agreement and the failure is not remedied within thirty days after notification of the other party.

Either party can terminate this agreement at any time without cause on forty-five days notice.

This agreement will renew automatically for an additional twelve-month period unless either party notifies the other of a desire to re-negotiate or terminate the agreement at least ninety days before the end of the twelve-month period.

<<Signatures and Typed Names and Dates>>

Partnership Physician Arrangements

Physician Incentive Plan

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organization is required by contract to ensure that physicians will not substitute financial reasons for medical reasons in determining what services should be provided to its members who are Medicaid recipients and/or Medicare beneficiaries.

Operating Guidelines:

Any incentive plan of the Partnership Organization must meet the following requirements:

1. Federal regulations, per Stark Laws I & II , 42CFR 422.208, 417.479, SSA Physician Incentive Plan 1903m)(2)(A)(viii) and SSA 1903(m)(4)that require :

    a. No specific payment of any kind be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or to limit medically necessary services. Indirect payments include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.
    b. If the Partnership Organization places a physician or physician group at substantial financial risk (as determined by the Secretary of the Department) for services not provided by the physician or physician group, the Partnership Organization shall:
        i Provide stop-loss protection for the physician or physician group that is adequate and appropriate based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

2. When a Medicare/Medicaid provider implements a Financial Incentive Plan, the provider must conduct surveys that:

    a. Include either all current Medicare/Medicaid members and individuals previously enrolled who have disenrolled during the past 12 months, or a sample of these same enrollees and disenrollees.
    b. Are designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis.
    c. Address consumer satisfaction with the quality of services provided and the degree of access to the services.
    d. Begin no later than one year after the effective date of the incentive plan. Thereafter, surveys must be conducted at least every two years.

3. Agencies that implement physician incentive plans must provide CMS and the Department information concerning the plans, sufficient to permit the Secretary to determine whether the plan is in compliance. Disclosure must be made upon application

for a contract or for a service area expansion, and upon request by CMS or the Department. The disclosure must contain the following information:

a. Whether the incentive plan covers services not furnished by the physician or physician groups. If the plan covers only the services furnished by the physician or physician group, disclosure of other aspects of the plan is not needed.
b. The type of incentive arrangement; for example, withhold, bonus, capitation.
c. If withhold or bonus, the percent of the withhold or bonus.
d. The amount and type of stop-loss protection.
e. The panel size and, if patients are pooled according to one of the following permitted methods, the method used.
f. Commercial, Medicare and/or Medicaid members in the calculation of the panel size.
g. Pooling together of several physician groups into a single panel.
h. Capitation payments, if any, paid to primary care physicians for the most recent year broken down by percent of primary care services, referral services to specialists, and hospital and other types of provider (for example, nursing home and home health agency) services.
i. The results of surveys.

4. Agencies must inform any Medicare/Medicaid beneficiaries whether they use a physician incentive plan that affects the use of referral services, the type of incentive arrangement, and, if available, the results of surveys.

Marketing and Member Materials

Marketing

Wisconsin Partnership Program Protocol:

All Partnership Organization's marketing information is required to be appropriate and accurate and not mislead, confuse, or defraud members or potential members. The Partnership Organization is required by contract to submit all marketing materials to the Department and CMS for approval before disbursement.

Operating Guidelines:

1. Marketing materials and the review process used by the Department and CMS are defined in the contract.

2. Member Handbooks. All member handbook materials will be consistent with the Evidence of Coverage Disclosure Information currently in effect. All handbook materials must be submitted to the Department and CMS for approval prior to disbursement.

3. Lock-In. Members must receive all covered health and long-term care services directly from or through the Partnership Organization or from sources that the organization has authorized while enrolled in the program.

Enrollment and Disenrollment Systems

Open Enrollment

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program must provide voluntary and continuous open enrollment up to the limits set under the Medicaid and Medicare contracts on a first come, first served basis.

Operating Guidelines:

1. Prior to being served on a first come first served basis, all Partnership members must meet the eligibility and enrollment criteria in the Wisconsin Partnership Program Protocol.

2. Exceptions to eligibility and enrollment appear in the Non-Enrollment protocol.

3. The following enrollment activities are prohibited:

    a. Practices that are discriminatory
    b. Activities that could mislead consumers
    c. Offers of gifts, compensation, benefits, or rewards as inducements to enroll

Enrollment and Disenrollment Systems

Eligibility Criteria

Wisconsin Partnership Program Protocol:

All potential members are screened for eligibility based on the criteria outlined in this protocol. Exceptions to eligibility and enrollment appear in the contract.

Operating Guidelines:

1. The potential member for the Elderly Model must:

    a. Be age 55 years or older,
    b. Reside in a county as specified in the contract to which this protocol is appended,

2. The potential member for the model for People with Physical Disabilities must:

    a. Be between 18 and 64 years of age,
    b. Reside in a county as specified in the contract to which this protocol is appended,
    c. Have a physical disability as their primary disabling condition.

3. All members and potential members must be certified as requiring nursing home level of care using the Functional Eligibility Screen or by other means approved by the Department and CMS. Eligible levels of care are ICF-1, ICF-2 and SNF. Although potential members who are at an ISN level of care are not eligible for Partnership, the Partnership Organization will continue to serve members who receive an ISN level of care after enrollment.

4. All members and potential members must be eligible for Medicaid.

5. Additional eligibility requirements affect members diagnosed with End Stage Renal Disease (ESRD). Please see Protocol *(ESRD, p.81)* for details.

6. Additional eligibility requirements affect members admitted to hospice. See Protocol *(Hospice and End of Life Services, p.82)* for details.

7. Additional eligibility requirements affect members who have received certain transplants. See Protocol *(Disenrollment Due to Non-Covered Transplants, p.47)* for details.

8. Additional eligibility requirements affect members who are eligible for Medicare benefits in addition to Medicaid benefits. See Protocol (Integration of Medicaid and Medicare Benefits *p.37) for details.*

9. The Non-Enrollment Protocol *(p.41)*will be applied to guide exceptions to enrollment of eligible individuals. (See Article VII of the Medicaid contract.)

Enrollment and Disenrollment Systems

Intake

Wisconsin Partnership Program Protocol:

The Partnership Organization will see and provide intake services to each person referred to the program who desires to proceed with the application process.

Operating Guidelines:

The intake process for the Wisconsin Partnership Program will include the following elements:

1. Providing Partnership Program information to the potential member and identifying the member's primary care physician.

2. Providing information on financial eligibility to potential members and offering to assist the potential member to make application for Medicaid. (See Financial Eligibility Protocol.)

3. Assessing for functional eligibility using the Long-term Support Functional Screen. (See Functional Eligibility Protocol.)

4. Obtaining member, guardian, or durable power of attorney for health care sign off on the initial plan of care.

5. Implementing the initial Personal Care Worker plan.

6. Staff from the Partnership Organization meet with the potential member and/or with the potential member's significant others, legal guardian, or durable power of attorney for health care to explain:

    a. The health benefits and services provided by the program
    b. Eligibility requirements
    c. Estate recovery (if applicable), cost share (post eligibility treatment of income) and other financial aspects

7. Staff will provide and explain to the potential member the handbook and list of current providers.

8. Staff will obtain a release of information if the potential member chooses to continue the intake process.

9. Staff will process functional eligibility.

Enrollment and Disenrollment Systems

Financial Eligibility

Wisconsin Partnership Program Protocol:

All Medicaid eligibility for members or potential members will be determined by the county department under contract with the State of Wisconsin to make Medicaid eligibility determinations. Potential members already enrolled in Medicaid will also be referred to the proper county department so that participation in the Wisconsin Partnership Program can be documented and the proper medical status codes can be assigned. Partnership Organizations will refer all potential members to the appropriate county department and will not make any statement that may lead potential members to believe that they are eligible or ineligible for Medicaid. Partnership Organizations may assist the potential members in making an application for Medicaid. The member or potential member must be eligible under the non-financial and financial rules of the Wisconsin State Medicaid plan or the Wisconsin Partnership Program Waiver.

Enrollment and Disenrollment Systems

Functional Eligibility

Wisconsin Partnership Program Protocol:

The member or potential member must meet functional eligibility as tested by applying the Functional Eligibility Screen at enrollment and annually thereafter.

Operating Guidelines:

1. Functional Eligibility

    a. The Intake Registered Nurse in the Partnership Organization will perform an in-person health assessment and review copies of medical records to determine functional eligibility and the need for daily living assistance.
    b. Based on the assessment and review of records, the Intake Team completes the Functional Eligibility Screen and prepares an initial plan of care for the potential member. The initial plan includes the potential member's diagnosis, medications, and recommendations for skilled nursing, therapies, personal care and medication management.

2. Functional Eligibility Re-determinations

    a. Re-determinations for functional eligibility (level of care) are required annually.
    b. If the Partnership Organization feels that the member's care needs have increased or decreased significantly, the Partnership Organization must complete a re-determination of the level of care.
    c. The Partnership Organization is not required to enroll anyone who requires Intensive Skilled Nursing (ISN). Individuals who, while enrolled in the Partnership Program, become ISN certified will remain enrolled.

Enrollment and Disenrollment Systems

Integration of Medicaid and Medicare Benefits

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program integrates Medicaid and Medicare benefits for members who are dually eligible. In order to continue their enrollment in the Wisconsin Partnership Program, members who are dually eligible must receive their Medicaid and Medicare Advantage services only from their Partnership Organization. Whenever a Partnership Organization is not able to fully integrate Medicaid and Medicare managed care services, the member may not be enrolled into a Partnership Organization, and must be involuntarily disenrolled. Partnership sites must inform members or potential members under these circumstances of their ineligibility for continued enrollment or enrollment and notify them in writing of their appeal rights.

Operating Guidelines:

1. All applicants or members who are eligible for Medicare must be enrolled in both Part A and Part B of the Medicare benefit.

2. If a member (a) is eligible for Medicaid only at the time of enrollment, and (b) later becomes eligible for Medicare then that member must become a beneficiary of both Medicare Part A and Medicare Part B to maintain eligibility for Wisconsin Partnership Program enrollment.

3. Most members or potential members should be eligible to have their Part B premiums paid by Medicaid. For those who are not eligible for Medicaid premium support, Part B premiums will contribute to the medical expenditures for "post eligibility treatment of income." In short, the requirement to obtain Part B coverage should not impose a burden on the great majority of enrollees. In the event that this proves not to be the case for individual enrollees, the State and CMS will review their circumstances and determine what course of action to take on a case by case basis.

4. In order to maintain eligibility, dually eligible members must choose Partnership as their Medicare Advantage plan.

Enrollment and Disenrollment Systems

EDS' Monthly Enrollment Reports

Wisconsin Partnership Program Protocol:

The Partnership Organization shall monitor EDS' enrollment reports and the individuals who are and are not included in the reports.

Operating Guidelines:

1. Function of Monthly Enrollment Reports.

    a. The EDS monthly reports are the Department's official notification about the enrollment and payment status of participants in the Partnership Program.
    b. The EDS monthly enrollment reports have the list of persons who are enrolled in the Partnership program and who will be listed on the Remittance and Status payment report. The names of individuals who are enrolled will appear as ADD or CONTINUE.
    c. Individuals whose names:
        - Do not appear in the EDS monthly enrollment reports are not enrolled, and therefore, will not receive Medicaid capitation payments.
        - Appear as PEND/CLOSE have recently lost Medicaid eligibility. Whenever these individuals are reinstated as Medicaid eligibles within a period of three months and with no lapse in Medicaid eligibility, the EDS Final Enrollment Reports will identify them as an ADD or CONTINUE.
    d. Article XV of the contract, "Functions and Duties of the Department" identifies the function of EDS enrollment reports.

2. Effective Date for Retroactive Enrollment. Once the County reinstates the Medicaid eligibility of a person, the Department will authorize EDS to retroactivate the enrollment of that person. The effective date for retroactive enrollment is within three calendar months from the date when the Partnership Organization notifies EDS that a member is not in the list of the monthly enrollment report and has been and continues being served by the organization.

Enrollment and Disenrollment Systems

Enrollment

Wisconsin Partnership ProgramProtocol:

Once it has been determined that a prospective member has met functional and financial eligibility requirements and agreed to enroll, the prospective member must sign an enrollment agreement and an enrollment request.

Operating Guidelines:

1. A Partnership Organization staff person will meet with the prospective member (and/or his or her guardian, power of attorney for health care, significant others, as appropriate) to review the following documents and obtain signatures, where applicable:

    a. Member Handbook/Evidence of Coverage (EOC). The Member Handbook contains key information the member needs to be fully informed about the decision to enroll, including informed choice and voluntary enrollment requirements (lock-in). A copy of the Member Handbook must be provided to the prospective member prior to enrollment.
    b. Provider Directory. The Provider Directory lists current providers.
    c. Enrollment Request Form. The Medicare and Medicaid enrollment requests are to be signed by the member. The Partnership Organization will forward the request to County Human Service department and to CMS for processing. d. Enrollment Agreement. The enrollment agreement is between the contractor and the member, outlining services, benefits, procedures, rights, and responsibilities. Partnership intake staff give one copy to the member, retain the other in permanent records of the contractor.

2. Once the member signs the enrollment agreement, the staff person will provide the member with copies of the following within one week:

    a. A copy of the Enrollment Agreement.
    b. Emergency instructions including phone numbers, to be posted in the member's home in case of emergency. Similar information will be provided on a wallet card, which the member will be asked to carry with their Medicaid and Medicare cards.
    c. Sticker for member's Medicare card, if applicable.

3. Enrollment processing

    a. The Partnership Organization, in accordance with the wishes of the potential member, may provide the county Medicaid eligibility agency with financial eligibility information. The county Medicaid eligibility organization will key needed information into the CARES system, transmitting the same information to the Medicaid fiscal intermediary.

b. If the member is Medicare eligible, the Partnership Organization will transmit electronic enrollment information to the Medicare enrollment agency to enroll the member in the Partnership Organization.
   The Medicare enrollment agency will instruct the appropriate Medicare fiscal intermediary to issue capitation payments to the Partnership Organization effective the first date of the month following the date the Enrollment Request was signed.
c. The Partnership Organization will retain file copies of all enrollment documents in the member record.
d. Whenever the enrollment of a member exceeds sixty (60) days, the Partnership Organization shall prepare an Enrollment Plan for that individual. An Enrollment Plan details the actions that are needed to facilitate and accelerate the enrollment of the prospective member. No enrollment of other potential members whose eligibility determination was completed after the date of the potential member experiencing the delay will occur until the delayed member is enrolled.
e. The Partnership Organization shall make Enrollment Plans available for the Department's review upon request.

Enrollment and Disenrollment Systems

Non-Enrollment

Wisconsin Partnership Program Protocol:

All people who meet eligibility criteria of the Partnership Program, and who are interested in enrolling as a member of a Partnership Organization, will be enrolled. The Partnership Program may, at its discretion, request permission not to enroll a potential member.

The Department shall grant a Partnership Organization's request for non-enrollment when the Partnership Organization demonstrates that one or more of the criteria for non-enrollment, as specified in Article VII of the Medicaid contract, are met.

Operating Guidelines:

1. The Partnership Organization does not have the authority to make non-enrollment decisions. Rather, the Partnership Organization may request a non-enrollment determination from the Department when any of the criteria for Non-Enrollment Protocols are met. The Partnership Organization's request should include contact information about the person, the reason for the non-enrollment request, and summary of the pertinent facts that is cross-referenced to supporting documentation.

    a. The Department will review the Partnership Organization's request for non-enrollment and either approve or disapprove the request for non-enrollment in writing within fifteen (15) working days of receipt of the request.
    b. If the Department approves the request for non-enrollment, the Partnership Organization will provide the potential member with written notice of the following information:
        i. That the Department granted the Partnership Organization's request for non-enrollment;
        ii. The specific protocol and documentation supporting the non-enrollment decision;
        iii. A statement about the member's right to challenge the non-enrollment decision;
        iv. A statement advising the applicant about the rights of the applicant to appeal the non-enrollment; and that the applicant may grieve in writing to the Department and/or, the Division of Hearings and Appeals.

    c. If the Department denies the request for non-enrollment, the Partnership Organization shall contact the person and offer enrollment.

2. The Partnership Organization shall be a party of interest in any grievance, appeal and/or reconsideration of a non-enrollment decision.

Enrollment and Disenrollment Systems

Disenrollment - Voluntary

Wisconsin Partnership Program Protocol:

Members have the right to request disenrollment from the Wisconsin Partnership Program at any time.

The Wisconsin Partnership Program Organization is prohibited by contract from counseling or otherwise influencing a member with a confirmed diagnosis of AIDS, as indicated by an ICD-9-CM diagnosis code or HIV- Positive who are on anti retroviral drug treatment approved by the Federal Drug Administration in such a way as to encourage voluntary disenrollment.

The Wisconsin Partnership Organization will work to assure the disenrollment process occurs as promptly and smoothly as possible. The Partnership Organization will facilitate the member's transition to Medicaid and/or Medicare, and other community services to which the member may be entitled.

Operating Guidelines:

1. Within five (5) days from the date a member notifies any Partnership Organization staff person of his or her intent to voluntarily disenroll, the Partnership Organization will send the member a Disenrollment Request Form for his or her signature.

2. Upon receipt of the Disenrollment Request Form signed by a member:

    a. A member of the Partnership Organization's staff will also sign and date the Disenrollment Request Form, acknowledging the request for disenrollment
    b. Return a copy to the member;
    c. Forward a copy to the County Human Services department;
    d. Forward a copy to CMS; and
    e. Forward a copy to the Department.

3. Whenever possible, disenrollment from Partnership should take place in accordance with the adverse action policy, at the end of the month following receipt of the request to disenroll. If a request for immediate disenrollment is received:

    a. Disenrollment from Partnership-Medicaid on the date that the disenrollment form was signed;
    b. Disenrollment from Partnership-Medicare will take place at the end of the current month in which the request is made.

Enrollment and Disenrollment Systems

Disenrollment - Involuntary

Wisconsin Partnership Program Protocol:

The Department may not grant a Wisconsin Partnership Organization's request for involuntary disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except as specified in these Protocols). The Department will consider a Wisconsin Partnership Organization's request for involuntary disenrollment when the Partnership Organization demonstrates that one or more of the criteria for involuntary disenrollment, as specified in Article VII of the Medicaid contract, are met.

The Wisconsin Partnership Organizations will work to assure the disenrollment process occurs as promptly and smoothly as possible. The Partnership Organization staff will facilitate the member's transition to Medicaid and/or Medicare, and other community services to which the member may be entitled.

Operating Guidelines:

1. The Partnership Organization must submit a request for involuntary disenrollment to the Department of Health and Family Services. A summary must be attached cross-referencing any supporting documentation.

2. The Department of Health and Family Services will approve or disapprove the disenrollment request based upon the criteria and procedures set forth in the contract between the Department and the Partnership Organization and notify the Wisconsin Partnership Organization of the Department's decision.

3. If the disenrollment request is approved by the Department, the Partnership Organization must notify the person in writing of the following:

    a. A statement that the Department has granted the Partnership Organization's request for disenrollment.
    b. The reason(s) the Department granted the disenrollment request (i.e. the specific protocol(s) that supports or requires the action).
    c. The effective date of the Department's adverse action.
    d. A statement about the member's right to challenge the decision to disenroll and how to appeal such decision.

4. When Department grants a disenrollment request, or the member becomes ineligible for the Partnership Program, the date of the disenrollment decision is an "adverse action date." The adverse action date will be determined in accordance with Addendum I of the Medicaid contract.

a. Loss of Financial Eligibility. If the member is determined to be financially ineligible, the adverse action date will be concurrent with the termination of member's Medicaid eligibility.
b. Loss of Functional Eligibility. If the member is determined to be functionally ineligible, the adverse action date is determined in accordance with number 5, below.
c. Out of Area Residence. If the member moves permanently out of the catchment area, the adverse action date shall be the date the move occurred as determined by the County Human Services Department .
d. Death. If the member dies, the date of disenrollment shall be the date of death.

5. The Department determines the effective date of an adverse action as follows:

    a. Loss of Financial Eligibility and Loss of Functional Eligibility. The effective date for disenrollments due to loss of financial eligibility and loss of functional eligibility is as follows:
        i. When the adverse action date is fourteen (14) days or more prior to the last business day of month, the effective date of the disenrollment will be the last day of the month in which the determination was made.
        ii. When the adverse action date is less than fourteen (14) days prior to the last business day of the month, then the effective date of the disenrollment will be the last day of month after the month in which the determination was made.
        iii. The adverse action dates are contained in Addendum I of the Medicaid contract.
    b. Out of Area Residence and Death. The effective date of disenrollments due to out of area residence and death is the date of the move and the date of death respectively.

6. Benefits while a Disenrollment Decision is on Appeal.

    a. If the effective date of the disenrollment decision is 10 days or less from the date the member receives the notice of disenrollment and the member files a written appeal within ten (10) days after receiving the notice of disenrollment, the member shall remain eligible to receive benefits from the Partnership Organization until the appeal is resolved.
    b. If the effective date of the disenrollment decision is 10 days or less from the date the member receives the notice of disenrollment and the member files a written appeal within forty-five (45) days after receiving the notice of disenrollment, the Division of Hearings and Appeals shall hear the member's appeal, but the member will not be eligible to receive benefits from the Partnership Organization while the appeal is pending.
    c. If the effective date of the member's disenrollment is more than ten (10) days from the date the member receives the notice of disenrollment and the member files his or her appeal on or before the disenrollment date, the member shall remain eligible to receive benefits from the Partnership Organization until the appeal is resolved.
    d. If the effective date of the member's disenrollment is more than ten (10) days from the date the member receives the notice of disenrollment and the member files his or her appeal within forty-five (45) days after the adverse action date, then the Division

of Hearings and Appeals will hear the case, but the member will not be eligible to receive benefits from the Partnership Organization while the appeal is pending.

7. If the Department approves the Partnership Organization's request to disenroll the member, the Partnership Organization must, within three (3) business days, forward copies of the Disenrollment Form to the Medicaid fiscal intermediary and the Medicare enrollment agency.

8. The Partnership Organization shall be a party of interest in any grievance, appeal, or re-consideration of a disenrollment decision.

Enrollment and Disenrollment Systems

Disenrollment Due to Incarceration

Wisconsin Partnership Program Protocol:

The Partnership Organization has legal responsibilities when a member is incarcerated.

Operating Guidelines:

1. Medicaid regulations state that "A person detained by legal process is not eligible for Medicaid benefits." According to Wisconsin Administrative Code HFS § 103.03(6),"legal process" means:

   > incarcerated because of law violation or alleged law violation, which includes misdemeanor, felonies, and delinquent acts. A person who returns to the court after observation, is found not guilty of a law violation by reason of mental deficiency and is subsequently committed to a mental institution shall not be considered detained by legal process.

2. Federal regulations determine that the ten-day advance notice due to Medicaid beneficiaries is not required when "the recipient has been admitted to an institution where he is ineligible under the plan for further services" (42CFR 431.313(c).

3. The Department will disenroll any member who is incarcerated on the date of incarceration. The Department will cease capitation payments on the day following the date of incarceration. Procedures for disenrollment include:

   a. The Partnership Organization will notify the individual about the reason for and date of disenrollment. The reason is the loss of Medicaid benefits due to incarceration. The disenrollment date is the date on which the individual was incarcerated.
   b. The Partnership Organization is not required to mention the right to appeal or grieve the disenrollment decision. (The County will notify the incarcerated individual about loss of Medicaid benefits and rights to appeal.)
   c. The Partnership Organization will indicate that the member may be entitled to fee-for-service Medicaid benefits until the end of the current or succeeding month, depending on the date of incarceration.

4. Right to Enroll. Any person who, after incarceration, becomes Medicaid eligible may apply for enrollment in the Partnership Organization.

Enrollment and Disenrollment Systems

Disenrollment Due to Non-Covered Transplant

Wisconsin Partnership Program Protocol:
Medicaid managed care and Medicare Advantage have conflicting disenrollment policies pertaining to disenrollment due to the following transplants: bone marrow, liver, heart, heart-lung, lung, pancreas and pancreas-kidney.

Operating Guidelines:

1. Anyone who has had one or more transplant surgeries listed above may not be enrolled in the Partnership Program. If a person with one or more transplant surgeries is accidentally enrolled in the Partnership Program, the Partnership Organization may request immediate disenrollment of that individual.

2. When a current member requires one of the transplants listed above, the hospital or provider of transplants is responsible for requesting and receiving prior authorization for all transplants performed on Partnership members.

3. The Partnership Organization shall make arrangements with the hospital or provider of transplants for the future performance of needed transplants.

4. The Partnership Organization will notify the EDS contract monitor about the authorized and upcoming transplant.

5. The Partnership Organization will inform the contract monitor in the Department about the authorized and upcoming transplant.

6. Once transplant surgery is performed, the hospital or provider of transplant services will inform the EDS contract monitor about the date of the surgery and will provide required documentation.

7. Upon receiving notification from the hospital or the provider that the transplant has been performed, EDS will permanently exempt the person from Partnership enrollment effective the day before the transplant was performed.

8. Upon approval of the prior authorization for a transplant, the Partnership Organization may ask the member to voluntarily disenroll from the Medicare Advantage portion of the Partnership Program.

Enrollment and Disenrollment Systems

Disenrollment Process

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to facilitate disenrollment, whether voluntary or involuntary.

Operating Guidelines:

The Partnership Organization shall process disenrollments in the following manner.

1. The Wisconsin Partnership Program Organization will continue to provide all needed services until the effective date of the Department's Disenrollment decision, upon which capitation payment ends.

   Whenever possible, disenrollment from Partnership should take place in accordance with the adverse action policy. Disenrollment from Partnership-Medicare will take place at the end of the month when Medicaid enrollment ceases. If Medicare disenrollment occurs during a hospital stay, the Partnership Organization will remain financially responsible through the entire hospital stay even if the stay extends beyond the date of disenrollment.

2. The Partnership Organization will notify the Medicare enrollment agency and the county Economic Support Worker if Medicaid eligibility was established through the county or the Social Security Administration if the person has SSI.

3. The Partnership Organization will notify the member of their disenrollment date.

4. The Partnership Organization Program Manager and Team members will notify the member's primary care physician, and coordinate the member's transition to Medicaid or Medicare services, and other community services to which the member may be entitled.

Member Rights

Rights and Responsibilities

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program recognizes the rights and responsibilities that its members have as the recipients of managed Medicare and Medicaid benefits, and the responsibilities of the Partnership Organization to facilitate the exercise of the members' rights and responsibilities.

Operating Guidelines:

The Partnership Organization is responsible for:

1. Treating its members with consideration, respect, and full recognition of their dignity and individuality.

2. Providing safe care, treatment, and services that are free of unnecessary physical and chemical restraint.

3. Facilitating the exercise of members' rights and responsibilities as recipients of managed Medicare and Medicaid benefits.

4. Explaining to members their rights and responsibilities as presented in: the Enrollment Agreement, Scope of available services and providers, Statement of member rights and responsibilities, Grievance and Appeals procedures, Policies on Privacy and Confidentiality, member's role in treatment plan decisions, Partnership Organization's rules and procedures.

5. Training staff on members's rights and responsibilities as the recipients of managed Medicaid and Medicare benefits.

Member Rights: The Partnership Organization recognizes that members, as the recipients of managed Medicaid and Medicare benefits, have the right to the following:

1. **Members have the right to be treated with dignity, respect and fairness at all times. This includes:**

    a. The right to be protected from discrimination due to age, race, color, sex, national origin or ancestry, religion, political belief or affiliation, disability, association with a person with a disability, sexual orientation, cultural or educational background, mental or physical ability, or source of payment for your health care.
    b. The right to be free from harm, including being free from abuse, restraint, neglect and discipline.
    c. The right to suggest changes in the way we work at the Partnership Organization.

d. The right to receive healthcare in a safe and clean setting.
e. The right not to be required to perform work for the Partnership Organization.
f. The right to have reasonable access to a telephone at Partnership Organization settings when present.

Members will be encouraged and helped to use their rights, including their rights under the rules of Medicare and/or Medicaid, should they choose.

2. **Members have the Right to full information about services covered and costs related to enrollment in Partnership Organization. This includes:**

    a. The right to be informed in writing of the services available by Partnership Organization before enrollment, at enrollment and anytime there is a change in services. This includes what costs are covered by the Partnership Organization, what costs members must pay and to receive an explanation from us about any bills they receive for services not covered by the Partnership Organization.
    b. The right to have the enrollment agreement fully explained to our members in a way they will understand.
    c. The right to receive a written copy of the Member Bill of Rights and to review these rights with the Partnership Organization staff in a way they understand.
    d. The right to review the most recent Medicare or Medicaid survey of the Partnership Organization, including the financial status.
    e. The right to get information about the qualifications of doctors and other health professionals and how we pay our providers.

3. **Members have the right to have access to medical services, including timely access to emergency services. This includes:**

    a. The right to access emergency care when and where our members have the need without approval from the Partnership Organization. Emergency care is a life-threatening situation or when the members' health is in danger and every second counts.
    b. The right to receive urgently needed services when traveling outside of the Partnership service area.

        The Partnership Organization will support member rights for information when hospitalized including notification from Medicare and Medicaid about the discharge process.

4. **Members have several rights in regard to health care providers. These include:**

    a. The right to choose a primary care physician that works within the Partnership Program and the right to choose from our network of specialists.
    b. The right to request a qualified specialist for women's health services for preventive or routine care.

c. The rights to timely access to a primary care provider and referrals to medical specialists when medically necessary.
d. To be told of any continuing treatments, the name of the provider and time and place of the appointment.

5. **Members have the right to fully participate in decisions about their health and to make informed choices.** This includes:

a. The right to be fully informed of the member's health status, how well the member is doing, and the prospects for recovering from an illness or injury
b. The right to have all treatment choices explained to our members in a way they understand and to allow them to participate in making and carrying out their plan of care.
c. The right to make health care decisions, including the right to refuse any treatments and to be told of the results that might happen if the member chooses to refuse treatment.
d. The right for members to choose a person they trust to act on their behalf if the member cannot fully participate in his/her treatment decisions or if the member wants to have someone to help them.
e. The right to be told about any medical risks involved in their treatment and to know whether the treatment is part of a research experiment.
f. The right to have the Partnership Organization explain Advance Directives to the member and to complete the form if the member chooses. This form gives medical providers instructions about the members' wishes for medical care in the event that they are unable to make their own decisions.
g. The right to be given notice of any transfer to another treatment setting and the reason why a member might be transferred.
h. The right to be informed about any medications prescribed, how to take them and their possible side effects.
i. The right to disenroll from the Partnership Programs any time.

6. **Members have the right to privacy and confidentiality of their medical records and personal information. This includes:**

a. The right to communicate with any member of the I-Team or other health care providers in privacy and to have confidentiality protected.
b. The right to have all health care information and personal information protected and remain confidential.
c. The right to review, copy and change their own medical records or personal information.
d. The right to request limits on how we use and share their personal information.
e. The right to request a listing of ways we have shared their personal information.

7. **Members have the right to information and assistance. This includes:**

a. The right to get help with a language or communication barrier so the member can understand all information provided.
b. The right to qualified interpreter services at no cost to the members. (Members have the right to not have to rely on their children, other relatives, or friends as interpreters.)

8. Members have the right to file grievances and appeals. This includes:

a. The right to a full explanation of the grievance and appeals processes.
b. The right to a fair and timely process for solving differences between the member and Partnership Organization.
c. The right to be encouraged to voice grievances to the Partnership Organization staff or outside representatives about the services received without any interference or chance of punishment.
d. The right to appeal any treatment decision by staff or other health care providers including involuntary disenrollment.
e. The right to file a grievance if you feel that any of your rights have been violated. Please contact us directly about your grievance. You can also contact one of the outside agencies as described in our grievance process.

Member Responsibilities: The Partnership Organization recognizes that members, as recipients of managed Medicaid and Medicare benefits, are responsible for:

1. Participating in the initial and ongoing development and implementation of the service plan.

2. Cooperating with the service plan by using authorized services and following the physician's orders.

3. Complying with the Emergency Services procedures.

4. Reporting health conditions in a timely manner.

5. Reporting changes in financial status.

6. Cooperating with the Partnership team and other service providers.

7. Participating in quality assurance processes.

8. Using Partnership providers unless the member and the Partnership Organization mutually agree otherwise.

9. Accepting services without regard of the provider's race, color, religion, age, gender, sexual orientation or national origin.

10. Allowing the release of records in the case of a transfer to another health care facility or as required by law or by a third party payment contract.

Program Operations

Interdisciplinary Team Model and Roles

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organization is required by contract to provide services through a comprehensive, interdisciplinary health and social services delivery system that integrates acute and long-term services.

Operating Guidelines:

1. The Partnership Organization will establish an interdisciplinary team consisting of a Nurse Practitioner, Social Worker/Social Services Coordinator, and Registered Nurse. These team members will be employed by or operate under the direction of the Partnership Organization.

2. Interdisciplinary Team Responsibilities:

    a. Team
        - Authorize and coordinate services.
        - Ensure member goals and preferences are identified, documented in the service plan and addressed.
        - Provide in-home assessment of safety issues and work with the member to manage risk.
        - Provide information and support to the member in making choices within the parameters of the Partnership Organization.
        - Develop, monitor and review the service plan with the member.
        - Facilitate the exercise of the member rights and responsibilities.
        - Evaluate the effectiveness of the current plan of care and implement modifications as needed in collaboration with the member and other providers as appropriate.
        - Provide education to the member and families regarding health and social needs.
        - Identify the member's informal support systems/networks in relationship to his or her functional and safety needs.
        - Report information to team members and appropriate heath care providers as needed.
        - Assess and assist the member in quality of life issues.
        - Meet documentation and reporting requirements in a timely and accurate manner.
        - Provide links/coordination with care provided across settings.
        - As appropriate, represent the member's point of view when the member is unable to participate in decisions.
        - Equipment/Supplies
    b. Nurse Practitioner

- Establish and maintain a collaborative relationship with the member's primary care physician to ensure coordinated, appropriate and individualized medical care for the member.
- Provide initial history and physical exam.
- Provide periodic re-evaluation of medical status.
- Provide evaluation of episodic illness in the member's residence or in an office/clinic setting.
- Ensure health maintenance standards are offered and accessible.
- Assume leadership role in collaborating with appropriate providers prior to, during, and at discharge from inpatient settings, sub-acute care settings, and short-term skilled nursing homes, and nursing homes.
- Order diagnostic or therapeutic interventions.
- Serve as primary liaison between the team, the member, and the Primary Care Physician.

c. Registered Nurse
   - Assess physical health status, response to illness.
   - Assess effectiveness of medications including intended effect, side effects, member knowledge and method of administration.
   - Provide in-home assessment to identify functional limitations and adaptations to environment.
   - Provide skilled nursing services to members.
   - In conjunction with the Nurse Practitioner, provide prevention and health maintenance education to members.
   - Assess the need for and coordinate supportive home care services provided to members.
   - Delegate appropriate aspects of member care to PCW; supervise and evaluate effectiveness of care given.
   - Ensure that the PCW written plan is reflective of member needs, current and provides sufficient direction to PCW.
   - Communicate acute changes in health status to NP in a timely manner and collaborate with NP in implementing interventions.

d. Social Worker/Social Services Coordinator
   - Provide psycho-social/economic assessment.
   - Explore financial options and eligibility, including employment services.
   - Provide information and assist member in housing issues.
   - Provide information and assist member in maintaining and establishing community links.
   - Provide on-going coordination of psycho-social services.
   - Assist in crisis intervention.
   - Provide assessment and coordination of mental health, alcohol or drug abuse services.
   - Provide supportive counseling as appropriate.

Program Operations

Interdisciplinary Team Contact Standards

Wisconsin Partnership Program Protocol:

The Partnership Interdisciplinary Team will have sufficient contact and interaction with the Member in order to develop and maintain a relationship and be responsive to changing Member needs.

Operating Guidelines:

Social Worker/Social Services Coordinator

1. The Social Worker/Social Services Coordinator will complete a face-to-face home assessment within four (4) weeks after enrollment.

2. On-going contact will occur monthly and will include face-to-face or telephone contact with the member or caregiver as appropriate. Collateral contact with another team member who is making in-person visits may be substituted when clinically relevant.

Registered Nurse

1. The RN will complete a face-to-face home assessment within four (4) weeks after enrollment.

2. On-going contact will occur monthly and will include face-to-face or telephone contact with the member or caregiver as appropriate. Collateral contact with another team member who is making in-person visits may be substituted when clinically relevant.

Nurse Practitioner

1. The NP will complete a face-to-face home assessment within four (4) weeks after enrollment.

2. The NP will see the member in the home for provision of medical care/monitoring every six (6) months at a minimum.

Program Operations

Member/Team Shared Responsibility for Use of Services

Wisconsin Partnership Program Protocol:

The Partnership Interdisciplinary Team and the member will jointly identify health and social services that are essential to the member's mental and physical health and safety. The team and the member will identify services necessary to support the member in the context of his/her own resources, capabilities and goals regarding work and participation in the community.

Operating Guidelines:

1. The team will explore with the member, ways in which she/he can address priority areas independently or through her/his informal support network, encouraging creative problem solving and maximizing the member's involvement.

2. The team and the member will explore existing resources in the community.

3. After exploring informal supports and member's resources, the team will evaluate the use of Partnership resources. An internal implementation process will be developed and followed.

4. The team will authorize services/items, consulting with others in the organization, as appropriate.

5. The team will seek the most appropriate and cost-effective solutions.

Program Operations

Interdisciplinary Team-Based Service Delivery

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organization is required by contract to provide or arrange for integrated health and long-term care services through an interdisciplinary team model. The team's approach is to develop a partnership with the member who has an active role in stating preferences, and responsibility for self-care.

Operating Guidelines:

1. Each member is assigned an interdisciplinary team, comprised of a Nurse Practitioner, Registered Nurse and Social Worker/Social Services Coordinator, at a minimum. Responsibility for assessment, care planning, service authorization and delivery, coordination, monitoring, health education and prevention rests with the team.

2. Team members and network providers shall have the expertise to meet the needs of the population being served.

3. The organization assures member access to services on a 24-hour basis. The member will have one phone number to call with problems 24 hours a day. The organization will have a system in place to respond to member calls within an hour.

4. Each team member conducts an individual assessment in the member's residence, which includes identification of the member's issues, needs, strengths and resources.

5. An individualized service plan will be developed with each member that clearly identifies member preferences, goals, specified treatments and strategies and the responsible person or provider.

6. The team will coordinate smooth transitions, assure continuation and oversight of member care and serve as an advocate in all settings in which the member may reside or receive care.

7. The team will obtain member and family input into care as well as the input of other providers and caregivers as appropriate.

8. The interdisciplinary team implements, monitors and coordinates the service plan by providing service directly and overseeing and coordinating the delivery of services by contract providers.

9. The team will monitor the member's health and psychosocial status as well as the effectiveness of and satisfaction with the service plan through direct provision of services, informal observation, diagnostics, input from the member, significant others, providers as appropriate, and communication among members of the team.

10. If the member resides lives in a congregate living facility the team will monitor the provider through observation, review of provider documentation, and member/family feedback.

11. The team will ensure all relevant health and social information and member preferences are available to providers at the point of service.

12. Health and psychosocial risk status will be monitored and assessed to trigger early interventions. Health promotion, including psychosocial issues and early detection and treatment of risks and problems will be emphasized.

13. The interdisciplinary team will meet regularly to review member issues and to conduct service plan reviews.

Program Operations

Interdisciplinary Team Assessment

Wisconsin Partnership Program Protocol:

The Partnership Interdisciplinary Team will conduct discipline specific in-home assessments of each member to identify the member's abilities, needs, preferences and supports.

Operating Guidelines:

1. Functional and financial eligibility will be conducted prior to enrollment.

2. The Registered Nurse, Social Worker/Social Services Coordinator and Nurse Practitioner will perform in-home assessments to identify issues, needs, strengths, and resources of each member and which care or service the family and/or support systems can provide.

3. The team will complete assessments within four (4) weeks after enrollment. The team will complete specific risk assessments as the need is identified.

4. Specific risk assessments will be completed as team members identify the need, particularly in the areas of (not listed in terms of priority):

    a. Medications
    b. Falls
    c. Skin integrity
    d. Pain
    e. Mobility
    f. Housing
    g. Social supports
    h. Mental health/depression
    I. Alcohol and other substance related self-abuse
    j. Violence/abuse/crime
    k. Financial means
    l. Nutrition

Program Operations

Assessments for Elderly Members

Wisconsin Partnership Program Protocol:

The Partnership Interdisciplinary Team will conduct discipline specific in-home assessments of each member to identify the member's abilities, needs, preferences and support.

Operating Guidelines:

The following assessments will be completed according to the minimum frequency guidelines:

Assessment	**Minimum Frequency**
History and Physical	Enrollment
Safety	Enrollment
Barthel or LTC-FS	Enrollment/annual/major change
ALSAR or LTC-FS	Enrollment/annual/major change
Psycho-Social Assessment Including: ▪ Informal support ▪ Communication ▪ Emotional/cognitive ▪ Social participation	Enrollment/annual
Medication Review	Enrollment/annual/post-hospital
Consumer Member Goals Including: ▪ Housing	Enrollment/Every six (6) months
Capacity for Self-Care	Enrollment/annual

Program Operations

Assessments for Members with Physical Disabilities

Wisconsin Partnership Program Protocol:

The Partnership Interdisciplinary Team will conduct discipline specific in-home assessments of each member to identify the member's abilities, needs, preferences and support.

Operating Guidelines:

The following assessments will be completed according to the minimum frequency guidelines:

Assessment	**Minimum Frequency**
History and Physical	Enrollment
Safety	Enrollment
Barthel or LTC-FS	Enrollment/annual/major change
ALSAR or LTC-FS	Enrollment/annual/major change
Psycho-Social Assessment Including: ▪ Education/Vocation ▪ Informal support ▪ Communication ▪ Emotional/cognitive ▪ Social participation	Enrollment/annual
Medication Review	Enrollment/annual/post-hospital
Consumer Goals Including: ▪ Housing	Enrollment/every six (6) months
Capacity for Self-Care	Enrollment/annual

Program Operations

Individualized Service Plan Development and Review

Wisconsin Partnership Program Protocol:

The Partnership Interdisciplinary Team shall develop a written individualized service plan with each member.

Operating Guidelines:

1. The team will include the member in the plan development and review, to the extent the member chooses. The desired outcome of this process is that the member has input into and a good understanding of the service plan, the services that can be provided and what is expected of him or her.

2. The team will develop an individualized service plan for each member within eight (8) weeks of enrollment.

3. The plan will be developed using the initial plan created by an RN, the member's preferences and goals, primary care physician input and the individualized assessments conducted by the team.

4. The individualized plan must contain measurable goals, specified treatment strategies or services and the person, provider, or community organization responsible for providing the services. Member goals and preferences must be identified in the plan.

5. The plan will address the 24-hour service needs of the member.

6. The entire plan will be reviewed at least every six (6) months or more often as the member's health, psychosocial status or setting changes.

7. The team will incorporate PCW and other provider input into the plan as appropriate.

8. The team will review the plan with the member initially and every six (6) months thereafter and will obtain the member's signature.

Program Operations

Personal Care Worker/Plan Development and Review

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program Organization is required by contract to provide access to personal care services. Personal care or daily living assistance services must be performed according to a written plan.

Operating Guidelines:

1. The Partnership Organization staff member will complete a personal care/daily living assistance service plan, with member input. The plan will include the member's preferences and input from the interdisciplinary team.

2. Information such as: family involvement, living conditions, the member's level of functioning and any pertinent cultural factors should be communicated to the Personal Care Worker.

3. The plan will be updated as the needs of the member changes. Any revisions to the plan will be communicated to the PCW.

4. The plan will be regularly reviewed and modified by the Partnership Registered Nurse, or designee, and the member. The review will involve evaluating the effectiveness and appropriateness of the plan and member satisfaction with the plan and the service providers.

5. Any delegated Nursing acts included in the plan must be under the direction and supervision of an RN.

Program Operations

Hiring and Paying Family Caregivers

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program Organization is required by contract to provide access to paid personal care services. The Partnership Organization shall pay for the services of a family member under the following circumstances:

1. When the Partnership team determines that the member requires paid personal care, and

2. The member will clearly benefit from a family member providing the care (e.g., decrease caregiver stress, decrease risk for housing placement) and prefers that a family member provides the care, and

3. The family member agrees to:
   a. Meet the Partnership Organization's hiring requirements, which include assessment for Basic or Advanced Competency Standards for PCW and meeting PCW training and monitoring requirements
   b. Maintain the Partnership Organization's performance expectations
   c. Work hours that may increase or decrease based on member need and are not guaranteed.

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Operating Guidelines:

The Partnership Organization shall maintain decision-making guidelines for determining under what circumstances a family member shall be hired and paid as a caregiver. The guidelines shall also include requirements for hiring, training, and ongoing performance.

1. The need for personal care is determined initially by the Intake RN, and by the interdisciplinary team thereafter.

2. When the Individual Service Plan is developed, the team will discuss Assessment findings with the member and determine whether home care services will be provided, who is best suited to provide the necessary care, and whether a family member will be paid using the organization's decision-making guidelines.

3. The Partnership Organization is responsible for ensuring the family caregiver is trained, the competency standards met and for developing a PCW Plan that specifies the services that will be provided, the number of hours initially authorized and the process by which changes may be made to those hours, based on member need.

4. The Partnership RN or designee will review the PCW Plan every six (6) months, at a minimum. Member feedback will be solicited and used in determining whether the family member should continue to be paid for providing home care.

5. The team will use onsite observation and member feedback to monitor the PCW Plan.

Program Operations

Physician/Nurse Practitioner Collaborative Practice Agreement

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program Organization has signed collaborative practice agreements with contracted primary care physicians. The practice agreement defines the working relationship between the primary care physician and Partnership nurse practitioner.

Operating Guidelines:

1. The Partnership Program Nurse Practitioner (NP) and the primary care physician will:

    a. Discuss the collaborative agreement and agree on a co-management practice, initially and over time
    b. Discuss the role of the Nurse Practitioner in the Wisconsin Partnership Program, which includes the following:
        i. Ensuring the Partnership Program health maintenance standards are offered and accessible to members.
        ii. Serving as a liaison between the team and the physician
        iii. Relaying the member's goals and priorities to the physician
        iv. Handling routine and non-complex health care matters and updating the physician on member status.

2. The Partnership Organization will obtain physician's signature on the Collaborative Practice Agreement, file the signed original and provide a copy to the physician.

Program Operations

Model Physician/Nurse Practitioner Collaborative Practice Agreement

Introduction

Nothing in this or in any other document or contract requires Physician to provide health care to Wisconsin Partnership Program Organization ("WPP organization") Members in general or to a particular WPP organization Member. This collaborative practice agreement outlines the Wisconsin Partnership Program requirements for Paragraph 8.10(7) of the Nursing Chapter in the Wisconsin Administrative Code and to document the collaborative relationship between Physician and the Advanced Practice Nurse Prescribers (also known as "Nurse Practitioners" and "NPs") employed by WPP organization in their provision of health care services provided to Members accepted into the Physician's practice.

1. Open Communication

   WPP organization NPs and Physician shall engage in open communication. Specifically, Physician agrees to be available (or have his/her designee available) for consultation with WPP organization NPs.

   If an WPP organization Member presents to an WPP organization NP with symptoms or a diagnosis which appears to exceed the competence of the WPP organization NP, the WPP organization NP shall consult directly with the Physician or his/her designee. Each individual WPP organization NP's competence is determined by the NP's education, training, and experience.

   Physician may limit this Agreement to specific areas of practice, which correspond with the areas of medical practice in which Physician concentrates and/or for which the Physician is specifically certified, credentialed, or granted privileges. In the event that a WPP organization Member presents to an WPP organization NP in a situation identified by the Physician in advance as being outside the limits of this Collaborative Practice Agreement, the WPP organization NP shall nevertheless provide Physician or his/her designee with timely notification of such an event.

2. WPP organization NPs Use of Prescriptive Authority

   Physician acknowledges that, in a manner consistent with applicable laws and regulations, any applicable practice guidelines, health care policies established by the clinic/program/hospital/WPP organization and any applicable employment agreement, WPP organization NPs may issue prescriptive orders and order laboratory testing, radiographs, and electrocardiograms.

   If a significant adverse event occurs to an WPP organization Member accepted into the Physician's practice as a result of a prescribing order, or laboratory test, radiograph, or

electrocardiogram, a WPP organization NP will notify Physician, if Physician is not involved in the management or review of that WPP organization Member's case.

3. No Mutual Indemnification

   Physician and WPP organization NPs acknowledge and agree that Physician and WPP organization NPs shall each remain legally responsible for their own practice and that neither assumes any legal liability or responsibility for errors or omissions on the part of the other party.

4. Term and Termination

   This Collaborative Practice Agreement will be effective as of the date Physician signs where indicated below. This Collaborative Practice Agreement will remain in effect for twelve (12) consecutive months, and will automatically renew on the anniversary of its effective date, unless canceled by either party in writing. Further, this Collaborative Practice Agreement shall be in effect only while Physician and WPP organization's NPs maintain their respective positions with the contracted physician group practice and WPP organization.

5. Certification

   By signing this Agreement, I certify that I have read it, understood all of its terms and conditions, and will abide by this Collaborative Practice Agreement.

Physician

_____ _____

Physician Date

Program Operations

Nurse Practitioner/Primary Care Physician Collaboration

Wisconsin Partnership Program Protocol:

The Nurse Practitioner (NP) works in collaboration with each member's primary care physician to jointly manage medical care, under a signed Physician/Nurse Practitioner Collaborative Practice Agreement.

Definition:

The Nurse Practitioner is a graduate of a Masters degree program and certified by a national accreditation body in advanced practice nursing. The NP has advanced skills in the assessment and management of physical and psychosocial health/illness of individuals. The NP also functions as health counselor and educator for members and their families. The NP may, with appropriate prescriptive authority, prescribe medications under Wisconsin Statues, Chapter 8.

Operating Guidelines:

The Nurse Practitioner will:

1. Attend physician clinic visits with the member when possible and appropriate.

2. Obtain a history and physical and systems assessment within four weeks of enrollment.

3. The Nurse Practitioner will serve as the primary liaison between the team, the member and the primary care physician.

4. Ensure health maintenance standards are offered and accessible to each member.

5. Monitor acute/urgent and chronic illnesses. The Nurse Practitioner may write prescriptive orders. The Nurse Practitioner will keep the primary care physician apprised of the member's health status and will collaborate on the medical plan of care.

6. Direct clinical monitoring, activity levels, diet changes, and skin/wound care.

7. Prescribe medications and order diagnostic laboratory tests as authorized under Wisconsin Statutes, Chapter 8 with appropriate prescriptive authority.

Program Operations

Nursing Practice

Wisconsin Partnership Program Protocol:

Standards of Nursing Practice for the Wisconsin Partnership Program will conform with the Wisconsin Nurse Practice Act. Nursing staff will perform only those duties in which they are competent, based on education, experience, or possession of a license.

Operating Guidelines:

1. Registered Nurses must obtain orders from the Wisconsin Partnership Program Nurse Practitioner or physician for all medications and invasive nursing procedures (e.g., catheterization, blood draws, tube feeding).

2. A Registered Nurse must be available for oversight of clinical practice for RNs, LPNs, and PCWs.

3. The Registered Nurse on the interdisciplinary team will supervise LPNs, Aides, and personal care workers.

    a. The Registered Nurse may delegate to an LPN or personal care worker only those tasks commensurate with educational preparation, certification or demonstrated abilities of the person performing the task.
    b. Satisfactory performance of these skills must be shown prior to assignment, and documented in the employee file.

4. A Registered Nurse or other appropriate professional shall be available to home health aides, personal care workers, and LPNs by telephone at all times and shall provide in-home supervision as necessary.

Program Operations

Health Maintenance Standards for the Elderly

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program Nurse Practitioner in collaboration with the primary care physician will ensure health maintenance services are offered and accessible to members.

Health Maintenance Standard	Minimum Frequency as recommended by the U.S. Preventive Services Task Force
History and Physical	Upon enrollment if not obtained within the past twelve (12) months
Health Maintenance Exam	Annually
Dental Exam	Annually if teeth present; otherwise as clinically indicated
Vision Exam	Every 1-2 years if 65 or older
Audiology	Upon enrollment if not obtained within the past twelve (12) months, and as clinically indicated
Mammogram	Every 2 years if 50-75, if life expectancy warrants As clinically indicated if over 75
Clinical breast exam	Annually, if life expectancy warrants
Pelvic with PAP	Every 1-3 years if life expectancy warrants (every 3 years after 2 consecutive annual negatives, stop if 2 negatives over age 65)
Immunization Status	Annual Review
Tetanus	Primary series; booster every 10 years
TB	Two-step PPD upon admission to Adult Day Center, Community-based Retirement Center, or Nursing Home or for members at high risk
Influenza	Annually 60 years or over; annually for < 60 if high risk (immunocompromised, multiple comorbidities)

Pneumococcal	Once per lifetime over age 65, but repeat every 5 years if immunocompromised; if 1st vaccine was before age 65 and greater than 5 years prior, give 1-time revaccination
Labs	Minimum Frequency
CBC	Upon enrollment if not recently obtained within the past twelve (12) months, and as clinically indicated
Chem Panel	As clinically indicated
TSH	Upon enrollment if not recently obtained within the past twelve (12), and as clinically indicated
Vit B12 and Folate	Upon enrollment if not recently obtained within the past twelve (12), and as clinically indicated
Urinalysis	As clinically indicated
Guiac/Colorectal Screening	Annually if 50 years or older, if life expectancy warrants
Colonoscopy	Every 10 years if 50 years or older, if life expectancy warrants, up to age 80-85
Depression screening	Annually
Osteoporosis screening	As clinically indicated
Diptheria immunization	Every 10 years after 55 years of age

Program Operations

Health Maintenance Standards for People with Physical Disabilities

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program Nurse Practitioner in collaboration with the primary care physician will ensure health maintenance services are offered and accessible to members.

Health Maintenance Standard	Minimum Frequency
History and Physical	Upon enrollment if not obtained within the past twelve (12) months) and annually thereafter
Health Maintenance Exam	Annually
Dental Exam	Annually
Vision Exam	Every year if diabetic or other risk factors Every 2-4 years if 40-64 Every 1-2 years if 65 or older
Stool for guaiacolorectal screening	Annually if 50 or over or other risk factors
Mammogram	Annually starting at age 40 for women of average risk. If there is a family history or other risk factors, frequency to be determined by Member's primary care physician
Clinical breast exam	Annually
Prostate-rectal exam (DRE)	Annually if 50 or over
Prostate Specific Antigen (PSA)	Annually if have 10 year life expectancy
Pelvic with PAP	Every 1-3 years (every 3 years after 2 consecutive annual negatives, stop if 2 negatives over age 65)
Immunization Status	Annual Review
Tetanus	Primary series; booster every 10 years
TB	Mantoux Two-step PPD in all members at increased risk

Influenza	Annually if over 60 years or as clinically indicated
Pneumococcal	As clinically indicated
Cholesterol	As clinically indicated
Flexsigmoidoscopy	Every 5 years starting at age 50 or as clinically indicated
Osteoporosis screening	As clinically indicated
Vitamin D	As clinically indicated

Program Operations

Inpatient Case Management

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program Organization is required by contract to provide access to hospital and nursing facility services. The Interdisciplinary Team will maintain contact with the member during hospitalization or nursing home stays.

Operating Guidelines:

1. Hospitalization
   Includes acute care hospitals, rehabilitation hospitals, psychiatric hospitals, subacute care, and short-term skilled nursing homes.

   a. The Partnership Organization will establish a procedure with all contracted hospitals to notify the Partnership Organization within 24 hours of member admission.
   b. The Partnership Organization Nurse Practitioner will ensure the Primary Care Physician is aware of the member's admission.
   c. The Nurse Practitioner in conjunction with the Primary Care Physician and the Medical Director will collaborate on a regular basis with hospital/nursing home staff on the provision of care to the member, including but not limited to:
      - Monitor member progress
      - Communicate member goals and priorities
      - Communicate medical/functional/psychosocial information to maximize member care
      - Evaluate appropriateness of continued hospitalization
   d. The Partnership Organization Nurse Practitioner will assess the member's status within seventy-two (72) hours of admission. The Nurse Practitioner will conduct this assessment by talking with hospital staff or by direct contact with the member, as the Nurse Practitioner determines appropriate.
   e. With the Primary Care Physician, the Partnership Organization Nurse Practitioner will identify and address any delays in service, identify outcomes that will lead to the member's discharge from the hospital or nursing facility, and ensure discharge planning, including other team members as appropriate.
   f. Based on the discharge plan, the team will make necessary revisions to the Individual Service Plan to fit the member's needs. The team will carry out the revised plan immediately upon discharge.
   g. The Partnership Organization Nurse Practitioner or Registered Nurse will visit the member within one week of discharge to assess the following:
      - Medications
      - Safety
      - Support systems
      - Nutrition
      - Mobility

- Mental health status
- Specific risks

h. A team member will make a second visit within two (2) weeks, when appropriate.

2. Nursing Home
   Includes long-term nursing facility placement.

   a. The Nurse Practitioner will monitor and order the following:
      - Labs
      - X-rays
      - Medications
      - Rehabilitation
      - Visit the member appropriate to the member's condition, but at least every other month.
      - Triage phone calls from nursing home staff.
      - Monitor the quality of care and intervene when necessary.
      - Along with other team members, communicate member goals and member/family concerns to nursing home staff.
      - Collaborate with the primary care physician on medical issues.
      - Report back to the team and involve team members as appropriate.

Program Operations

Protective Placement

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program Organization will support the intent of Chapter 55, the Wisconsin Protective Services Law. It is also the policy of the Wisconsin Partnership Program to assess each individual and to initiate, modify or terminate a protective placement order if appropriate.

Background:

Chapter 55 (SEC. 55.001) contains a declaration of the Legislature's intent in creating a protective service system. Under sec. 55.001, the declared policy of the state is to:

1. Establish protective services for people who need them because of the infirmities of aging, chronic mental illness, mental retardation, other developmental disabilities, or like incapacities incurred at any age.

2. Protect individuals in need of protective services from exploitation, abuse and degrading treatment.

3. Assure the availability of protective services to all people when in need of them.

4. Allow people in need of protective services, to the maximum degree of feasibility, the same rights as other citizens.

5. Place the least possible restriction on personal liberty and exercise of constitutional rights consistent with due process and protection from abuse, exploitation and neglect.

Chapter 55 relies heavily on counties to operate the protective service system. Chapter 55 requires each county board of supervisors to designate one or more county departments to have responsibility for local planning to implement the protective service system. The county may designate one or more of the following departments: Human Services, Social Services, Community Programs (51.42) and Developmental Disabilities Services (51.437).

Operating Guidelines:

1. The Wisconsin Partnership Organization will need to determine which county department is responsible for the protective service system.

2. The Partnership Organization will have detailed procedures for staff to follow in order to either initiate, modify or terminate a protective services placement.

3. The Partnership Team will refer members with protective service issues to that county department.

4. If a member has a protective placement order at the time of enrollment, the Partnership Team will work with the designated county department in order to provide service in accordance with the order.

Program Operations

Housing

Wisconsin Partnership Program Protocol:

All Partnership members shall have the opportunity to live in a private home unless there are essential health or long-term support needs that cannot be met in such a setting. When congregate housing is necessary, the Partnership Organization will consider and support the member's choice and independence to the greatest extent possible, given the member's individual circumstances and preferences.

Definitions:

A Private Home is a house or apartment (with locking doors and full kitchen and bath facilities) occupied by a single person or family group. A family is formed by blood relationship, marriage, or other lasting bonds of affection or mutual and consensual cooperation.

Congregate Housing describes any facility where unrelated people live in a single common residence:

An Adult Family Home is a traditional private home (house or apartment) where the family accepts one to four additional people who need support to live in the community. That support may be as simple as a structured environment and meals, or may also include some personal care. (Licensed by the County as an Adult Family Home).

Alternate Housing Facilities include Community Based Residential Facilities (CBRFs), Group Homes, and Assisted Living. These facilities may provide some personal care or supervision to residents but do not generally provide skilled nursing care or intensive rehabilitative therapies. Residents of these facilities must have a reasonable level of privacy, choice of association with others and choice of participation in various daily occupational activities. Alternate Housing is considered to be more restrictive for the member than living in a Private Home, but less restrictive than Non-acute Inpatient Care Facilities.

Non-acute Inpatient Care Facilities include Hospices, Nursing Homes, Rehabilitation Facilities, Skilled Nursing Facilities, Transitional Care Facilities or Respite Facilities. In addition to basic personal care, these facilities may provide skilled nursing care and intensive rehabilitative therapies. Non-acute Inpatient Care Facilities are considered to be more restrictive for the member than living in Alternate Housing, and substantially more restrictive than living in a Private Home.

Rehabilitation: Those treatments and services provided to restore a higher level of function to a person, thereby increasing or restoring that person's capacity to live more independently.

Maintenance: The same or similar treatments and services may also be provided where the treatment goal is only to maintain a current level of function or to slow functional decline. Rehabilitation or Maintenance services may include physical therapy, speech therapy, occupational therapy, mobility training, and others, and may be provided in any residential setting.

Respite Care is a service designed to provide relief to a community care giver.

Operating Guidelines:

1. The level of support needed, cost, and the options available in a particular community may all influence the feasibility of various housing options. The team will discuss these factors with the member. The service plan will record this discussion and note where the member prefers to live. Housing needs and preferences will be reviewed with the member every six months, when the service plan is reviewed.

2. Members will not be placed in Congregate Housing unless:

    a. The member is cognitively impaired, and the formal and informal support system is not sufficient to meet essential health or long-term support needs, and the Interdisciplinary Team also documents a significant risk to the member; or
    b. The member is medically frail, requires substantial hands-on overnight care either permanently or on a long-term basis, and the Partnership Organization has documented efforts to support the member at home using formal and informal supports.

3. If a member is placed in Congregate Housing, the member's Individual Service Plan must include a plan for the member's return to a less restrictive living situation, including a schedule of reviews of the Congregate Housing arrangement itself and an appraisal of the Partnership Organization's capacity to meet the health and long-term support needs of the member at home.

4. If a member refuses to leave Congregate Housing when the team determines that it is no longer necessary, the team will work with the member to identify and remove barriers to moving to a private home or less restrictive setting.

5. If an individual resides in Congregate Housing at the time of enrollment and has no desire to relocate to a less restrictive setting, the Partnership Organizations may request a denial of enrollment from the Department.

Program Operations

End Stage Renal Disease

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program Organization is required by contract to serve people who are diagnosed as having ESRD and meet all applicable eligibility requirements.

Operating Guidelines:

1. The Partnership Organization will enroll or disenroll members with end stage renal disease according to the eligibility table below:

PARTNERSHIP AND ESRD

ESRD Scenarios - Pre-enrollment	1	2	3	4
Medicaid Eligible at Enrollment?	Yes	Yes	Yes	Yes
Medicare Eligible at Enrollment?	No	Yes	No	Yes
ESRD Status at Enrollment?	Yes	Yes	No	No
Will Medicaid Partnership enroll?	Yes	No	Yes	Yes
Will Medicare enroll?	No	No	NA	Yes
ESRD Scenarios - Post -enrollment	5	6		
When did the person become Medicare eligible relative to ESRD?	Before	After		
Will Medicaid Partnership continue Enrollment?	Yes	No		
Will Medicare continue enrollment?	Yes	No		
Will Medicaid enhance Capitation?	No	NA		
Will Medicare enhance Capitation?	Yes	NA		

Program Operations

Hospice and End-of-Life Services

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program Organization is required by contract to provide access to Hospice services from a Medicare Certified Hospice Provider. The Partnership Organization may directly provide end-of-life services as an alternative to Hospice services.

Operating Guidelines:

1. Dual Eligible for Medicare and Medicaid

   When a Partnership member is eligible for and wishes to receive hospice services from a Medicare certified Hospice program the member, at his/her discretion, may remain enrolled in the Partnership Program. If the member is certified for hospice care, the plan will receive a full Medicare capitation payment for the month in which the certification occurs but no Medicare capitation payments for the subsequent months. The Medicaid capitation payment will remain as it was prior to Hospice enrollment.

   If the member wishes to receive their non- hospice services through the Partnership Program, the Partnership Organization must have a signed memorandum of understanding in place with the Hospice organization that identifies how care will be coordinated in these situations. The memorandum of understanding must identify issues such as prior authorization, team decision making and how care will be coordinated. The Partnership Program will bill Medicare on a fee-or-service basis for any services provided.

   The Partnership Organization may also contract for hospice services for a member at the member's discretion. In this case, the member will not be enrolled in the Medicare Hospice program and the Partnership Organization will continue to receive both the Medicare and Medicaid capitation payments. The Partnership Organization will contract with a hospice organization to provide hospice services or portions thereof. In no case, may the Partnership Organization represent itself as a hospice provider, unless certified by Medicare.

2. Eligible for Medicaid Only

   When a Partnership member is eligible for and wishes to receive hospice services in a Hospice program the member may disenroll from the Partnership Program and enroll in a Hospice Program. The Partnership Organization will facilitate the disenrollment from the Partnership Program and transition to a Hospice program.

   If the member wishes to receive their Medicaid services through the Partnership Program then the Partnership Organization must have a signed memorandum of understanding in

place with the Hospice organization that identifies how care will be coordinated in these situations. The memorandum of understanding must identify issues such as prior authorization, team decision making and how care will be coordinated.

The Partnership Organization may also contract for hospice services for a member at the member's discretion. In this case, the member will not be enrolled in the Medicaid Hospice program and the Partnership Organization will continue to receive the Medicaid capitation payment. The Partnership Organization will contract with a hospice organization to provide hospice services or portions thereof. In no case, may the Partnership Organization represent itself as a hospice provider, unless certified by Medicare.

Complaints and Appeals

Members' Rights

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to recognize and protect the rights granted to members by statute, regulation, and by the contracts between the Partnership Organization and the State and Federal governments.

Operating Guidelines:

The Partnership Organization shall recognize and protect the following rights related to the Complaints and Appeals processes.

1. Members have the right to work with their care Teams and with other Partnership Organization staff to resolve problems informally.

2. Members have the right to make Complaints, either with the Partnership Organization or with the State Managed Care Ombuds.

3. All members have the right to file an Appeal. The procedure used to adjudicate a particular Appeal is dependent upon the member's Medicare eligibility and whether the service at issue is covered by Medicare.

4. Members have the right to receive information about how to make a Complaint and file an Appeal. This information is found in the Wisconsin Partnership Program Member Handbook (also known as the "Evidence of Coverage" or "EOC").

5. Members have the right to freely express concerns and grievances without fearing discrimination in health care treatment.

6. Members have the right to request that the process for adjudicating their Complaint or Appeal be expedited; this request will be granted or denied in accordance with the contract and these protocols.

7. Members have the right to appoint an authorized representative for the Complaints and Appeals processes.

8. Members have the right to continue receiving health care during the Complaint and Appeals processes as required by the contract and these protocols.

9. Members have the right to receive notice about any changes in the Complaint and Appeals processes.

10. Members have the right to have all information regarding Complaints and Appeals maintained in a confidential manner.

11. Members have the right to be free from discrimination when they exercise their right to file a Complaint or Appeal.

Complaints and Appeals

Rights belonging to the Partnership Organization

Wisconsin Partnership Program Protocol:

The Department is required by contract to recognize and protect the rights granted to the Partnership Organization by statute, regulation, and by the contracts between the Partnership Organization and the State and Federal governments.

Operating Guidelines:

The Department shall recognize that the Partnership Organization has the following rights related to the Complaints and Appeals processes.

1. Whenever the Partnership Organization's coverage decision is upheld, the Partnership Organization may institute procedures to recover the cost of furnished medical services as allowed under the contract.

2. The Partnership Organization is an interested party in any Appeal filed by a member pertaining to (a) a determination of eligibility for the Partnership Program; (b) an involuntary disenrollment decision; and (c) a non-enrollment decision.

Complaints and Appeals

Informal Dispute Resolution

Wisconsin Partnership Program Protocol:

The Partnership Organization, the Department of Health and Family Services, and the Centers for Medicare and Medicaid Services recognize that not all problems rise to the level of a Complaint or an Appeal. Furthermore, the Partnership Organization, the Department of Health and Family Services, and the Centers for Medicare and Medicaid Services recognize that most problems can be resolved when members work with their care teams. Therefore, the Partnership Organization is directed to encourage members to always discuss problems with their care teams as a first step in the dispute resolution process.

NOTE: Nothing in this Protocol for Informal Dispute Resolution is intended to hinder members's right to make a formal Complaint or file an Appeal. If a particular problem rises to the level of a Complaint or an Appeal, then the Partnership Organization is required by contract to follow the applicable Complaint and Appeals Protocols.

Operating Guidelines:

1. The Partnership Organization shall encourage communication and feedback from members and their families. Specifically, the Partnership Organization shall encourage members and their families to comment about their own expectations and concerns, and to discuss creative ways to find solutions.

2. The Partnership Organization shall establish and maintain procedures for the fair and prompt resolution of problems raised by members and/or their families. The procedure shall be in writing and available to consumers and staff.

3. The Partnership Organization staff shall document informal dispute resolution in individual members' charts as required by applicable professional standards.

4. The Partnership Organization shall not discriminate against members who exercise their right to communicate a problem, make a Complaint or file an Appeal.

5. The Partnership Organization shall keep a record of all appeals and complaints and provide regular reports to the Department and CMS.

Complaints and Appeals

Complaints

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to establish and maintain procedures for the fair and prompt adjudication of Complaints filed by members and/or their families[1].

Operating Guidelines:

1. Definition of "Complaint" - A member (or a member's family) may make a Complaint pertaining to any problem that the member is experiencing with the Partnership Organization or with care providers that is unrelated to non-payment of a service.

    a. Complaint topics include, but are not limited to:
        - quality of services;
        - office waiting times;
        - the behavior of service providers (e.g. doctors, nurses, therapists, personal care workers, transportation personnel, etc.); and/or
        - adequacy of facilities.
    b. The Partnership Organization may not require that members submit Complaints in writing; the Department does not distinguish between oral and written Complaints.

2. The Partnership Organization shall inform members, verbally and in writing, about the Partnership Program's Complaint procedures at the time of enrollment. These materials will include the Wisconsin Partnership Program Member Handbook (also known as the "Evidence of Coverage" or "EOC"). The Partnership Organization's enrollment staff will show potential members where the Appeals materials are located in the EOC.

3. The Partnership Organization will establish an internal process to receive, consider, and resolve members' Complaints.

    a. The process will include the creation of an Advisory Group[2] which will have representation of consumers or peers, advocates, outside experts, and Partnership Organization personnel including member(s) of the Quality Assurance committee.
    b. This Advisory Group will review all written Complaints and will recommend resolutions to management.

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[1] *All regulations connected with Medicare complaints and appeals are contained in 42CFR Sections 422.560 – 422.639 (Sub-part M). Medicaid regulations can bwe found in 42CFR Sections 438.400 – 438.499 (Sub-part F).*

[2] *The advisory group will not include anyone outside the direct employ of the Partnership Organization or non-medical personnel in the case of a medical complaint, without the signed consent of the member, or the member's authorized representative, making the complaint.*

c. The process will include officials from the Partnership Organization who have authority to enforce a corrective action.
d. The procedure shall be in writing and available to members, providers and staff.
e. The Partnership Organization will inform members, providers, staff and the Department of all changes in procedures at least two weeks prior to implementation.

4. Within five days after receiving a Complaint, the Partnership Organization will inform the member and/or member's family about the decision regarding the Complaint.

5. The Partnership Organization will appoint a coordinator who will maintain a log of all Complaints and their resolution and forward this log to the Department upon request.

6. The Partnership Organization will require, via written contract, that all network providers cooperate in the Partnership Organization's process to receive, consider, and resolve members' Complaints.

7. The Department shall also establish a process to receive, consider and resolve members' Complaints. The Department meets this obligation through the Managed Care Ombuds.

   a. Partnership Organization shall inform members how to contact the State Managed Care Ombuds. The Partnership Organization complies with this requirement by giving members an approved Member Handbook (also known as an "Evidence of Coverage" or "EOC").
   b. The Managed Care Ombuds shall offer members assistance in resolving Complaints and in writing a formal Complaint.
   c. The Managed Care Ombuds will send a letter to any member who files a Complaint with the Ombuds. This letter will acknowledge receipt of the Complaint, and will be sent within seven (7) working days from the date that the Ombuds receives the member's Complaint.

Complaints and Appeals

Partnership Organization's Internal Processes to Respond to Requests for Items and Services

Wisconsin Partnership Program Protocol:

The Partnership Organization will establish an internal process to receive, consider and respond to members' requests for items and services. The Partnership Organization will respond to members' requests for items or services either on an Expedited basis or using a Standard process.

Operating Guidelines:

1. The Partnership Organization shall designate staff to process requests for items and services.

    a. The designated staff shall be equipped to receive all requests for items and services. Any member or the member's representative (including a physician) may request an item or a service either orally or in writing. Therefore, if the request is oral, the designated staff shall document in writing the request and whether it was received by phone or face-to-face.
    b. The designated staff shall determine and document the time and date the request was received by the Partnership Organization.
    c. Requests are handled using either an Expedited Process or on a Standard Process. The Expedited Process is required when the Partnership Organization is notified that the member feels that the requested item or service is urgently needed in order to avoid serious harm to the member's health. Therefore, the designated staff shall determine and document whether there has been a request to have the request handled on an expedited basis.
    d. The designated office or department shall be able to receive statement(s) from any physician who requests or supports the member's request. NOTE: No physician support is required for a request for an item or service, but if the member does present physician support, then the Partnership Organization must review support from any physician regardless of whether the physician is a network-physician or a non-network physician, and regardless of whether the support is in writing or via oral communication with the Partnership Organization.

2. The Partnership Organization shall meet the following timelines to handle requests for services on an Expedited basis:

    a. Whenever a member (or their authorized representative) feels the member needs an item or service to avoid serious harm to the member's health AND the member (or representative) communicates this feeling to the Partnership Organization, the Partnership Organization is required to handle this communication as a request for an Expedited Review.

b. If the request is accompanied by support from a physician or if there is no physician support, but the Partnership Organization agrees that a quick answer is needed, then the Partnership Organization will grant or deny the request, in writing, within three (3) calendar days. NOTE: The Partnership Organization may extend the 3-calendar day timeframe up to 14 total calendar days, but only if the extension is for the member's benefit and the Partnership Organization obtains the Department approval. If the Partnership Organization fails to give the member an answer within three (3) calendar days, the member may appeal to the State Managed Care Ombuds Program or to the Wisconsin Division of Hearings and Appeals.

c. If the request is not accompanied by support from a physician, the Partnership Organization has the authority to decide whether a quick answer is needed or not. If the Partnership Organization decides an expedited review is not necessary, then the Partnership Organization shall deny the request in writing within three (3) calendar days and give the member (or representative) notice that he/she may (i) resubmit the request for an expedited review with the support of a physician and/or (ii) appeal to the State Managed Care Ombuds Program or to the Wisconsin Division of Hearings and Appeals. If the request for an expedited review is not re-submitted, then the Partnership Organization shall grant or deny the request for the item or service using the Standard Review Process outlined below. If the Partnership Organization fails to follow any of these time frames, the member (or representative) may submit an appeal to either the State Managed Care Ombuds Program or the Wisconsin Division of Hearings and Appeals.

d. If the Partnership Organization agrees to provide the item or service, the PartnershipOrganization will authorize or provide the item or service as quickly as the member's health requires, but no later than three (3) working days from the date the Partnership Organization notifies the member of the favorable decision. If the Partnership Organization fails to follow this timeframe, the member (or representative) may appeal to the State Managed Care Ombuds Program or to the State Division of Hearings and Appeals.

e. If the Partnership Organization denies the request for the item or service, the Partnership Organization must follow the notice provisions below.

3. The Partnership Organization shall meet the following timelines to handle requests for items or services on a Standard basis.

a. If the member (or authorized representative) does not request his/her appeal be handled on an Expedited basis, then the Partnership Organization will respond to the request for an item or service in no more than fourteen (14) days. The Partnership Organization may extend this time an additional fourteen (14) days, but only if the enrollee requests it or if the Partnership Organization justifies the need for more information.

b. If the Partnership Organization agrees to provide the item or service requested, the Partnership Organization must authorize or provide the item or service as quickly as the member's health requires, but no later than thirty (30) days from the date the request was submitted. If the Partnership Organization fails to provide the member with the item or service within thirty (30) days, the member (or representative) may

appeal to the State Managed Care Ombuds Program or to the State Division of Hearings and Appeals.

c. If the Partnership Organization denies the request for the item or service, the Partnership Organization must follow the notice provisions below.

4. When the Partnership Organization denies a request for an item or a service, the Partnership Organization will notify the member in writing of the following:

   a. The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any;
   b. Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf;
   c. For service denials, a description of both the standard and expedited reconsideration processes and timeframes, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;
   d. For payment denials, a description of the standard reconsideration process and time frames, and the rest of the appeals process; and
   e. The beneficiary's right to submit additional evidence in writing or in person.

5. The following is an example of language that is not acceptable because it is not specific enough or understandable:

   You required skilled rehabilitation services-P.T. eval. for mobility + gaiteval. for ADL's, speech eval. swallowing - from 6/5/2001, and these services are no longer needed on a daily basis.

6. The following are examples of language that is acceptable because it is specific to the individual's case:

   a. The case file indicated that while Jane Doe was making progress in her therapy programs, her condition had stabilized and further daily skilled services were no longer indicated. The physical therapy notes indicate that she reached her maximum potential in therapy. She had progressed to minimum assistance for bed mobility, moderate assistance with transfers, and was ambulating to 100 feet with a walker. The speech therapist noted that her speech was much improved by 6/12/2001, and that her private caregiver had been instructed on safe swallowing procedures and will continue with feeding responsibilities.
   b. Golf carts do not qualify as durable medical equipment as defined under Medicare guidelines. Medicare defines durable medical equipment as an item determined to be necessary on the basis of a medical or physical condition, is used in the home or an institutional setting, and meets Medicare's safety requirements. A golf cart does not meet these requirements and is not payable by Medicaid, Medicare or the Partnership Organization.

Complaints and Appeals

Appeals – In General

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to establish and maintain procedures for the fair and prompt adjudication of Appeals filed by members and/or their families. The Partnership Organization, the Department of Health and Family Services and the Centers for Medicare and Medicaid Services acknowledge that there will be different Appeals processes available to members, depending upon the individual member's eligibility for Medicare and the issue on appeal.

Operating Guidelines:

1. A member (or the member's family) may file an Appeal if:

   a. The Partnership Organization denies prior authorization for a service or refuses to provide a service to a member who has requested the service;
   b. The Partnership Organization reduces a previously approved service that the member is presently receiving;
   c. The Partnership Organization denies payment for a service that a member has already received and paid for or the Partnership Organization refuses to reimburse a provider for a service that a member has already received and not paid for;
   d. The Partnership Organization fails to respond in the required time to a request for services or payment;
   e. The Wisconsin Department of Health and Family Services disenrolls the member on an involuntary basis; or,
   f. The Wisconsin Department of Health and Family Services grants the Partnership Organization's request for non-enrollment.

2. The first step in the Appeals Process is dependent upon the member's eligibility status (i.e. MA only or dually eligible) and the issue on appeal. (NOTE: for easy reading, "Partnership Organization" is abbreviated as "PO").

6.

Issue on Appeal	Member is eligible for Medicaid but not Medicare	Member is eligible for both Medicaid and Medicare
Discharge after a Medicare covered hospitalization	Member may access: 1. PO internal expedited appeals process 2. PO internal standard appeals process 3. State Managed Care Ombuds 4. Wisconsin Division of Hearings & Appeals	Member may access: 1. MetaStar independent review 2. PO internal expedited appeals process 3. PO internal standard appeals process
Termination of Medicare Covered Services provided by a SNF, CORF	Member may access: 1. PO internal expedited appeals	Member may access: 1. MetaStar fast track review

or HHA	process 2. PO internal standard appeals process 3. State Managed Care Ombuds 4. Wisconsin Division of Hearings & Appeals	2. PO internal expedited appeals process 3. PO internal standard appeals process
Denial of PA for, denial of payment for, and reduction of all other items and services covered by Medicare	Member may access: 1. PO internal expedited appeals process 2. PO internal standard appeals process 3. State Managed Care Ombuds 4. Wisconsin Division of Hearings & Appeals	Member may access: 1. PO internal expedited appeals process 2. PO internal standard appeals process
Denial of PA for, denial of payment for, and reduction of any item or service NOT covered by Medicare	Member may access: 1. PO internal expedited appeals process 2. PO internal standard appeals process 3. State Managed Care Ombuds 4. Wisconsin Division of Hearings & Appeals	Member may access: 1. PO internal expedited appeals process 2. PO internal standard appeals process 3. State Managed Care Ombuds 4. Wisconsin Division of Hearings & Appeals
PO's failure to response to a request for an item or service in a timely manner	Member may access: 1. PO internal expedited appeals process 2. PO internal standard appeals process 3. State Managed Care Ombuds 4. Wisconsin Division of Hearings & Appeals	Member may access: 1. PO internal expedited appeals process 2. PO internal standard appeals process
Enrollment/Disenrollment	Wisconsin Division of Hearings & Appeals	Wisconsin Division of Hearings & Appeals

3. The Partnership Organization will establish an internal process to receive, consider, and resolve Members' Appeals.

    a. The process will include the creation of an Advisory Group that will have representation of consumers or peers, advocates, outside experts, and Partnership organization personnel including Member(s) of the Quality Assurance committee.
    b. This Advisory Group will review Appeals and will recommend resolutions to management. Appeals by members will be only be reviewed by the advisory group with the written consent of the member. Members have the right to refuse review by the advisory committee, consist with CMS approved Member Handbook.
    c. The process will include officials from the Partnership Organization who have authority to command action.
    d. The procedure shall be in writing and provided to Members, providers, and staff.
    e. The Partnership Organization will inform Members, providers, staff and the Department of all changes in procedures at least two weeks prior to implementation.

4. The Partnership Organization will have a formal agreement with an advocacy group or organization to assist Members in processing their written Appeals without any charge to

the Member. The Partnership Organization will give the name, address and phone number of this advocacy group to Members at enrollment.

5. The Partnership Organization shall inform Members, verbally and in writing, about the Partnership Program's Appeals procedures at the time of enrollment. These materials will include:

   a. The Wisconsin Partnership Program Member Handbook (also known as the "Evidence of Coverage" or "EOC") – the Partnership Organization's enrollment staff will show potential Members where the Appeals materials are located in the EOC.
   b. The name, address and phone number of the organization that, without any charge to the Members, assists Members with preparing their complaints and appeals.

6. In general, the Partnership Organization has the contractual and legal obligation to provide appropriate health care to Members during the formal Appeals process. Exceptions to this general rule are set forth in the Contracts between the Partnership Organization and DHFS and CMS.

7. The Partnership Organization will appoint a coordinator who will maintain a log of all written Appeals and their resolution and will submit quarterly reports to the Board of Directors, to the Quality Assurance/Quality Improvement Committee, and to the Department (DHFS).

8. The Partnership Organization will not discriminate against any Member who exercises his/her right to file an Appeal.

Complaints and Appeals

Partnership Organization's Internal Appeals Processes
Denial of Coverage for an Item or Service

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to establish and maintain procedures for the fair and prompt adjudication of Appeals filed by members and/or their families when the Partnership Organization denies coverage of an item or service.

Operating Guidelines:

1. Whenever the Partnership Organization decides to reduce the amount or frequency of an item or service, the Partnership Organization is required to provide the Member with written notice at least ten (10) days in advance.

    a. If the Member's physician orders the reduction, then the Partnership Organization is not required to send the Member additional notice.
    b. It is not a reduction in service if the Member has received all of the services that the Partnership Organization originally authorized.

2. The Member (or authorized representative) has a choice of where to begin an Appeal. These choices are set forth in the Protocol entitled, "Appeals – In General."

3. Regardless of where the Member (or representative) starts the Appeals process, the Member (or representative) has two deadlines to consider:

    a. If the Member submits an appeal before the reduction takes place or within ten (10) days after receiving the notice that the Partnership Organization decided to reduce the amount or frequency of an item or service (whichever comes later), then the Partnership Organization must continue to provide the item or service until the Appeals process is completed.
    b. The Member must request an Appeal within sixty (60) days of the day the Partnership Organization notifies the Member that the Partnership Organization decided to reduce the amount or frequency of an item or service. The Partnership Organization is not required to hear appeals filed after sixty (60) days. However, the Member may submit, and the Partnership Organization must respond to, a request for additional services.

4. The Member (or representative) may submit the Appeal with or without the help of a physician.

5. To request an Appeal, the Member (or authorized representative) must mail or deliver the written appeal to the Partnership Organization. The Partnership Organization is not required to process oral requests for an Appeal.

6. There are two kinds of Appeals.
    a. Standard (30 days). A member may ask for a Standard appeal, and the Partnership Organization must give the member a decision no later than 30 days after the Partnership Organization receives the Appeal. The Partnership Organization may extend this time by up to 14 days if the member (or representative) requests an extension, or if the Partnership Organization needs additional information and the extension benefits the member.
    b. Expedited. (72 hour review)- The member (or representative) may ask for an expedited appeal if the member, his/her representative or doctor believes that the member's health could be seriously harmed by waiting too long for a decision. The Partnership Organization must decide on an expedited appeal no later than 72 hours after it receives the Appeal. The Partnership Organization may extend this time by up to 14 days if the member (or representative) requests an extension, or if the Partnership Organization needs additional information and the extension benefits the member.
    c. If any doctor asks for an expedited Appeal for a member, or supports the member in asking for one, and the doctor indicates that waiting for 30 days could seriously harm the member's health, the Partnership Organization will automatically give the member an expedited appeal.
    d. If the member (or representative) asks for an expedited appeal without support from a doctor, the Partnership Organization will decide if the member's health requires an expedited appeal. If the Partnership Organization does not give the member an expedited appeal, the Partnership Organization will decide the appeal within 30 days.

Complaints and Appeals

Partnership Organization's Internal Appeals Processes
Reduction in Coverage for an Item or Service

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to establish and maintain procedures for the fair and prompt adjudication of Appeals filed by members and/or their families when the Partnership Organization reduces the amount or frequency of an item or service a member is receiving.

Operating Guidelines:

1. Whenever the Partnership Organization decides to reduce the amount or frequency of an item or service, the Partnership Organization is required to provide the member with written notice at least ten (10) days in advance.

    a. If the member's physician orders the reduction, then the Partnership Organization is not required to send the member additional notice.
    b. It is not a reduction in service if the member has received all of the services that the Partnership Organization originally authorized.

2. The member (or authorized representative) has a choice of where to begin an Appeal. These choices are set forth in the Protocol entitled, "Appeals – In General."

3. Regardless of where the member (or representative) starts the Appeals process, the member (or representative) has two deadlines to consider:

    a. If the member submits an appeal before the reduction takes place or within ten (10) days after receiving the notice that the Partnership Organization decided to reduce the amount or frequency of an item or service (whichever comes later), then the Partnership Organization must continue to provide the item or service until the Appeals process is completed.
    b. The member must request an Appeal within sixty (60) days of the day the Partnership Organization notifies the member that the Partnership Organization decided to reduce the amount or frequency of an item or service. The Partnership Organization is not required to hear appeals filed after sixty (60) days. However, the member may submit, and the Partnership Organization must respond to, a request for additional services.

4. The member (or representative) may submit the Appeal with or without the help of a physician.

5. To request an Appeal, the member (or authorized representative) must mail or deliver the written appeal to the Partnership Organization. The Partnership Organization is not required to process oral requests for an Appeal.

6. There are two kinds of Appeals.

a. Standard (30 days). A member may ask for a Standard appeal, and the Partnership Organization must give the member a decision no later than 30 days after we get the Appeal. The Partnership Organization may extend this time by up to 14 days if the member (or representative) requests an extension, or if the Partnership Organization needs additional information and the extension benefits the member.
b. Expedited. (72 hour review)- The member (or representative) may ask for an expedited appeal if the member, his/her representative or doctor believes that the member's health could be seriously harmed by waiting too long for a decision. The Partnership Organization must decide on a fast appeal no later than 72 hours after the Partnership Organization receives the appeal. The Partnership Organization may extend this time by up to 14 days if the member (or representative) requests an extension, or if the Partnership Organization needs additional information and the extension benefits the member.
c. If any doctor asks for an expedited Appeal for a member, or supports the member in asking for one, and the doctor indicates that waiting for 30 days could seriously harm the member's health, the Partnership Organization will automatically give the member an expedited appeal.
d. If the member (or representative) asks for an expedited appeal without support from a doctor, the Partnership Organization will decide if the member's health requires an expedited appeal. If the Partnership Organization does not give the member an expedited appeal, the Partnership Organization will decide the appeal within 30 days.

Complaints and Appeals

Partnership Organization's Internal Appeals Processes
Denial of Payment for an Item or Service

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to establish and maintain procedures for the fair and prompt adjudication of Appeals filed by members and/or their families when the Partnership Organization denies payment for an item or service.

Operating Guidelines:

1. Whenever the Partnership Organization receives a bill for an item or services already provided to a member and then denies payment, the Partnership Organization must provide the member with written notice of this decision immediately after the decision was made, but in no event later than thirty (30) days after the Partnership Organization received the bill.

2. Whenever the Partnership Organization denies payment for an item or service the member has already received, the member (or authorized representative) has a choice of where to begin an Appeal. These choices are set forth in the Protocol entitled, "Appeals – In General."

3. Regardless of where the member (or representative) starts the Appeals process, the member (or representative) must request an Appeal within forty-five (45) days of the day the Partnership Organization notifies the member that Partnership Organization has refused to pay for the item or service the member has received.

4. The member (or representative) may submit the Appeal with or without the help of a physician.

5. To request an Appeal, the member (or authorized representative) must mail or deliver the written appeal to the Partnership Organization. The Partnership Organization is not required to process oral requests for an appeal.

6. The Partnership Organization must give the member a decision no later than thirty (30) days after it receives the Appeal. If the Partnership Organization agrees to make the requested payment, then the Partnership Organization must make the payment within sixty (60) days after the member filed his/her Appeal. There is no Expedited Process for denial of payment.

Complaints and Appeals

Appeals Outside of the Partnership Organization

Wisconsin Partnership Program Protocol:

The Partnership Organization shall cooperate with the Appeal process as determined by the Department, the Centers for Medicare and Medicaid Systems (CMS), and the judicial system.

Operating Guidelines:

1. The Partnership Organization will participate in the Appeals process as an interested party and as required by the Department and/or CMS.

2. The Partnership Organization will comply with the determinations that the Department, CMS, and the judicial system may issue relative to members' Appeals.

3. Members eligible for Medicare benefits have four levels of appeal available to them after the Partnership Organization has denied the member a Medicare covered service and the member has exhausted the Partnership Organization's internal appeals process:

   a. Reconsideration by MetaStar;
   b. Hearing by an Administrative Law Judge, if at least $100 is at issue;
   c. Departmental Appeals Board (DAB) Review; and
   d. Judicial Review, if at least $1000 is at issue.

4. Members who are not eligible for Medicare benefits, and members who are eligible for Medicare benefits but who appealing non-Medicare benefits, have two places where they may file an Appeal: the State Managed Care Ombuds, and the Wisconsin Division of Hearings and Appeals. These agencies do not require members to exhaust their Partnership Organization Appeal procedures prior to filing.

Quality Assurance and External Review

Quality Assurance/Improvement

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organization is required by contract to have a comprehensive Quality Assurance and Improvement (QA/QI) program that protects, maintains, and improves the quality of care provided to its members.

Operating Guidelines:

1. The Partnership Organization will develop and implement the QA/QI program and annual QA/QI plans.

2. The Board of Directors is accountable for overseeing the QA/QI program. The Board of Directors:

   a. Approves the agency's comprehensive QA/QI program and annual QA/QI plans.
   b. Reviews, on a periodic basis, written QA/QI reports and annual written reports.

3. The Partnership Organization's QA/QI program will:

   a. Include:
      - A QA/QI coordinator who is responsible for the operation and success of the program.
      - A QA/QI committee to implement all aspects of the program which will include both medical and psychosocial professionals.
      - QA/QI personnel sufficient to meet the goals of the program.
      - QA/QI annual plan.
   b. Establish annual quality goals based on information from Utilization Management, Member Health, Risk Management, Complaints and Appeals, and results of QI studies.
   c. Require the cooperation and participation of providers and subcontractors.
   d. Develop or adapt practice guidelines and standards of care to assure quality service among direct care and contracted providers.
   e. Monitor effectiveness of corrective actions until problems are resolved.
   f. Involve members in QA/QI initiatives. This may be accomplished through use of focus groups, consumer advisory councils or other member activities.
   g. Have a comprehensive QA/QI program that protects, maintains and improves the quality of care provided while maintaining and/or improving the quality of life for the member.
   h. Evaluate the overall effectiveness of the QA/QI program annually.

4. The Annual QA/QI Plan will include, but is not limited to:

    a. Annual QA/QI studies to identify areas for quality improvement.
    b. A minimum of two of the following studies must be completed each year for elderly members. Suggested topics include:
        - Identification and Integration of Enrollee/Caregiver Goals (as required as part of the demonstration research)
        - Monitoring Medication Profiles to Identify and Prevent Medication-Related Risks
        - Transportation Systems
        - Physical, Occupational, and Speech Therapies
        - Hospitalization and Post Discharge Care Management
        - Population-Specific Routine Screening and Prevention
        - Depression and Mood Disorder
        - Constipation and Fecal Impaction
        - Personal Care Worker Program
        - Falls With or Without Fracture
        - Urinary Incontinence
        - Pain Management
        - Nutrition
        - Appeals/Complaints
        - Nursing Home and Post Discharge
    c. A minimum of two of the following studies must be completed each year for persons with physical disabilities. Suggested topics include:
        - Identification and Integration of Enrollee/Caregiver Goals (as required as part of the demonstration research)
        - Assistive Technologies
        - Transportation Systems
        - Physical, Occupational, and Speech Therapies
        - Hospitalization and Post Discharge Care Management
        - Population-Specific Routine Screening and Prevention
        - Depression and Mood Disorder
        - Physical Environment and Access
        - Pain Management
        - Drug and Alcohol
        - Backup Systems
        - Nutrition
        - Communication
        - Bowel Programs
    d. Annual evaluation of member satisfaction, including but not limited to satisfaction with:
        - The knowledge and sensitivity of all service providers, including the team and PCWs.
        - Access to services
        - Member participation

e. Other studies may be conducted for elderly members or persons with physical disabilities in areas that are problem prone or appear to be especially high risk or high volume.

Quality Assurance and External Review

External Review

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organization is required by contract to assist the Department of Health and Family Services (Department) and the External Quality Review Organization (EQRO) under contract with the Department in identifying and collecting information required to carry out on-site or off-site medical chart reviews, interviews with care teams and members.

Operating Guidelines:

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1. The Department may request that an EQRO assists in external quality review preparation and implementation.

2. If the EQRO identifies an adverse health situation which needs correction, the EQRO will notify the Department who in turn will notify the Partnership Organization.

3. The Partnership Organization will:

    - Assign staff persons to conduct follow-up;
    - Inform QI committee on findings and involve committee in developing, and monitoring corrective action;
    - Submit corrective action plan to Department within timeframes specified by the Department for approval.

Utilization

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Organization is required by contract to ensure that there are mechanisms in place to detect both under-utilization and over-utilization of services.

Operating Guidelines:

1. The Partnership Organization will have documented policies and procedures for utilization review that reflect current standards of medical practice in processing requests for initial or continued authorization of services.

2. The Partnership Organization will adopt practice guidelines that are based on:
    a. The current clinical practice guidelines for health care professionals in their particular field of expertise,
    b. The needs of the enrollees,
    c. Consultation with contracting health care professionals,
    d. Periodic review for appropriateness with updates provided as needed.

The Partnership Organization will have health information systems in place to ensure that data received from providers and Third Party Administrators are accurate and complete.

Human Resources

Orientation Program

Wisconsin Partnership Program Protocol:

All Partnership staff, including Personal Care Workers ("PCW"), will complete an orientation program within two months of employment.

Operating Guidelines:

1. Orientation for all staff will include the following:

    a. The purpose and philosophy of the Wisconsin Partnership Program
    b. Integrated health and long-term care responsibilities
    c. Mission and principles of the Wisconsin Partnership Program
    d. General knowledge of the Partnership Organization
    e. The role of the member in the Partnership Program
    f. Member rights and responsibilities
    g. Cultural competency
    h. Confidentiality
    i. Communication
    j. Personnel policies
    k. QA/QI
    l. Infection control
    m. Complaints and Appeals process

2. Additional orientation requirements for team members

    a. Operational components
        i. Referral
        ii. Intake
        iii. Enrollment
        iv. Service delivery and coordination
        v. Assessment
        vi. Service plan
        vii. Documentation and data collection requirements
    b. Roles and function of the team
    c. Specific team members' responsibilities
    d. Individual educational needs
        i. Review results of knowledge and skills inventory
        ii. Educational plan to meet knowledge and skill needs

Human Resources

Social Worker/Social Services Coordinator Qualifications

Wisconsin Partnership Program Protocol:

The Social Worker/Social Services Coordinator must have the appropriate skills and knowledge to provide social services to Partnership members.

Operating Guidelines:

1. Social Services Coordinators must have the following skills and knowledge:

    a. A course of study leading to a BA/BS degree in a health or human services related field and one-year experience in working with individuals of the specific target group for which they are employed to work (this does not include a registered nurse degree of less than four years); or
    b. A minimum of four (4) years experience as a long-term support care manager; or
    c. An equivalent combination of training and experience that equals four years.

Human Resources

Verification of License or Certification

Wisconsin Partnership Program Protocol:

The Partnership Organization is responsible for verifying the registration, certification or licensure of staff before employment and at the required intervals. Staff required to have license or certification verified are nurse practitioners, registered nurses, licensed practical nurses, and therapy staff.

Operating Guidelines:

1. Pre-employment

    a. Current Wisconsin licensure and/or certification are verified by the Partnership Organization prior to employment.
    b. The Partnership Organization records the registration number and expiration date in the staff member's personnel file.

2. The Partnership Organization will have a process to annually, or as necessary, verify current registration prior to the expiration date.

3. Employees not having current licensure/certification as required by their job function shall not be permitted to work until such licensure/certification is current.

Human Resources

Competency Program

Wisconsin Partnership Program Protocol:

The Partnership Organization will ensure that all Partnership Program employees are competent to fulfill their assigned responsibilities.

Operating Guidelines:

1. Team members and PCWs will complete a knowledge and skills inventory upon employment and annually or more frequently as appropriate.

2. The Partnership Organization will identify employee and individual knowledge and skill needs, based on the inventory.

3. The Partnership Organization will address critical individual training needs immediately.

4. A performance appraisal will be completed annually for all staff. The appraisal will be based on a position description and skills competency inventory list as appropriate.

5. Team members will participate in training in integrated health and long-term care consistent with the findings of the quality research and the curriculum developed by the quality research team or the Academy for Quality and Comprehensive Community Services.

6. The Partnership Organization will be responsible for ongoing competency training related to the population being served.

7. The Partnership Organization will have an internal policy on CPR certification and recertification.

Human Resources

Assessment and Assignment of Personal Care Worker/Skills

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to ensure that each Personal Care Worker (PCW) is competent to perform tasks assigned to them (including basic personal care and/or advanced skills) prior to performing those tasks for a member. PCW tasks will be performed in compliance with the standard of practice in Wisconsin, including (where appropriate) proper delegation and supervision by a Registered Nurse, and proper documentation of the delegation and supervision.

Operating Guidelines:

1. Basic Skills

a. Basic skills of the PCW/DLA will be assessed at hire, re-assessed annually or more frequently as appropriate.
b. Documentation of these assessments will be kept in the employee file and/or the medical record of the member who is receiving PCW/DLA services.
c. Training materials and procedures will be developed to address deficiencies.
d. Basic skills include:
    i. Communication
    ii. Confidentiality
    iii. Observation and reporting
    iv. Infection control
    v. Documentation
    vi. Safety
    vii Body Mechanics
    viii. Positioning
    ix. Assistance with eating
    x. Elimination
        - Peri care
        - Toileting
        - Care of urinary catheters
        - Incontinence care
    xi. Hygiene
        - Bathing
        - Skin care
        - Oral care
        - Nail care
    xii. Dressing/Undressing
    xiii. Transfer techniques

xiv. Assisting with ambulation
- Cane
- Crutches
- Walker
- Wheelchair

xv. Range of motion
xvi. Care of Equipment
xvii. Assist with pre-dispensed oral medications and suppositories

2. Advanced Skills

a. Advanced skill needs for a member will be identified by an RN assessment.
b. An RN will teach the PCW/DLA the necessary advanced skills.
c. Satisfactory performance of these skills must be demonstrated prior to assignment and documented in the employee file and/or the medical record of the member who is receiving PCW/DLA services.
d. The RN will be responsible for supervising these delegated activities.
e. Re-assessment will be performed annually or more frequently, based on the RN's professional judgment and documented in the employee file.
f. Performance of PCW/DLA advanced skills are considered member specific and may not be performed by the PCW/DLA for another member without an RN assessment and assignment.
g. Advanced skills may include but are not limited to:
   i. Vital signs
   ii. Capillary blood glucose measure
   iii. Wound care
   iv. ostomy care
   v. Bowel program
   . Tube feedings

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Administration

Administration and Management

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to use the Partnership name and act in a manner that reflects the Wisconsin Partnership Program's integrity, effectiveness and reputation for consumer responsiveness. The Partnership Organization is required by contract to have administrative and management systems to support the Partnership Program's mission as a community-based, consumer-responsive organization that integrates health and long-term care service delivery.

Operating Guidelines:

1. During the dual waiver demonstration, the Department will only authorize public or private not-for-profit organizations to operate as a site for the Wisconsin Partnership Program. The Department will require Partnership Organizations be:

    a. Not-for-profit organizations or public entities; and
    b. Freestanding community-based organizations.

2. Governing Body. The Partnership Organization is required by contract to have the following administrative structures and systems in place:

    a. The governing body of the Partnership Organization will oversee the operation of the Wisconsin Partnership Program site. The governing body will be knowledgeable about the Wisconsin Partnership Program's integrated health and long-term care mission and responsibilities. The governing body will oversee development of a mission statement for the Partnership Organization that is consistent with the mission of the Wisconsin Partnership Program. The governing body has ultimate responsibility to assure that the policies and procedures of the Partnership Organization are consistent with the mission and goals of the Wisconsin Partnership Program.

    b. The governing body will include consumer representation. The governing body's membership will have a minimum of 25 percent consumer representation, of which at least two-thirds are members or enrollees (not a family member or advocate). The Partnership Organization will have a plan for selecting and training consumer representatives to enable them to participate effectively in all aspects of the deliberations of the governing body. Consumer representatives will have an active role in the selection of new members of the governing body. Committees of the governing body will include people with appropriate knowledge and skills in the areas of health and long-term care.

c. The governing body will ensure that the organization has a viable plan to implement the Wisconsin Partnership Program. The plan must include appropriate policies, staffing, information systems and training in the "Partnership model."

d. The governing body is ultimately accountable for Partnership Organization's internal quality assurance, complaint and appeals processes for the Wisconsin Partnership Program. The governing body will be encouraged to actively participate in the Partnership Organization's QA/QI system, including participating in processes to obtain member feedback and reviews of member complaints and appeals.

e. Members of the governing body will enforce conflict of interest policies and procedures that include disclosure of a direct or indirect interest in any contract for supplying service or material to the Partnership Organization. Members of the governing body will remove themselves from all decisions in which they have a conflict of interest. The Partnership Organization will disclose the direct and indirect interest of members of its governing body in annual reports and audits.

3. Management and Personnel

a. The Partnership Organization will have a chief executive whose appointment and removal are voted upon by the Partnership Organization's governing body. Executive pay will not be based on cost savings generated by operating a site for the Wisconsin Partnership Program or other managed care programs. The chief executive will be knowledgeable about the Partnership's integrated health and long-term care mission and responsibilities.

b. The Partnership Organization will have a full-time Partnership Project Director/Manager. The responsibilities of this position will be described in writing.

c. The Partnership Organization will have a Medical Director. The responsibilities of this position will be described in writing.

d. Management will implement systems to plan, administer and evaluate the organization's finances, marketing, health and long-term care services, quality assurance program, administration and management in accordance with the WPP Protocols.

4. Plans, Processes and Committees. The Partnership Organization is required by contract to establish the following plans, processes and committees:

a. Plans for:
   i. Training and orientation for members of the governing board

ii. Affirmative action
iii. Compliance with American Disabilities Act
iv. Marketing
v. Quality Assurance/Quality Improvement
vi. Utilization Management
vii. Physician Incentive (if utilized)
viii. Infection Control

b. Programs and Processes for:
i. Emergency Services, On Call and Back Up
ii. Quality Assurance/Quality Improvement Program and Coordination
iii. Health Education and Prevention
iv. Grievance and Appeals Coordination
v. Expedited Review of grievance
vi. Health Care Coordination
vii. Medical Chart Review Processes
viii. Enrollment and Disenrollment
ix. Record Maintenance Systems
x. Non-Discrimination
xi. Cultural Competency

c. Advisory Groups or Committees for:
i. Readability of Marketing Materials
ii. Quality Assurance/Quality Improvement
iii. Grievance Resolution
iv. Utilization Management
v. Ethics
vi. Medical Advisory

5. Assurances

a. To assure full and fair disclosure, the Partnership Organization must prepare a written description of the following:
i. Services or benefits (services including pre-authorization requirements, limitations and exclusions)
ii. Coverage (conditions on eligibility)
iii. Deductible, co-pay, cost share, and member liability
iv. Complaints and appeals, and expedited review
v. Geographic service area
vi. Participating providers in the network
vii. Financial information including assets, liabilities and net worth

b. This description must be written in a manner that is easily understood and made available to the public upon request.

Administration

Ethics Committee

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to have an active Ethics Committee that is accessible and responsive to the Partnership Organization staff, members and their families, and the community.

Operating Guidelines:

1. The Ethics Committee will include Partnership Organization staff, members, family, and community representatives.

2. The functions of the Ethics Committee are:

    a. To be a resource and guide and facilitate ethical decision-making.
    b. To inform and counsel, presenting alternatives to ethical questions and concerns, to members, their families and agency staff.
    c. To provide a forum to discuss and make recommendations in regard to ethical issues related to member care.

3. The Ethics Committee may be used to develop written policies and procedures for the review of:

    a. End of life decisions
    b. Advance Directives
    c. Do-Not-Resuscitate (DNR) orders
    d. Other ethical questions

Administration

Cultural Competency

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to provide culturally competent care.

Operating Guidelines:

1. Definition. Cultural Competency means providing services with sensitivity, understanding, and respect for the individual culture.

2. The Partnership Organization will incorporate in its policies as well as in its administrative and service practices the values of:

    a. Honoring member beliefs
    b. Sensitivity to cultural diversity
    c. Respect to cultural backgrounds

3. The Partnership Organization will develop specific strategies to address the cultural and linguistic needs of its members.

4. The Partnership Organization will educate its staff on member cultural backgrounds as well as on social and family issues unique to certain minorities.

5. The Partnership Organization will provide interpreters, bilingual assistance, and translations to members with language barriers in order to facilitate their access to services. The Partnership Organization will offer information in languages understood by its members. The organization's materials will inform its members how they can access interpreter services.

6. The Partnership Organization will expect and foster cultural competency among providers. The Partnership Organization will:

    a. Communicate its policies on cultural competency to subcontractors.
    b. Select qualified providers who are knowledgeable and experienced with the special health, long-term support, and cultural needs of its target population.
    c. Permit members to choose network providers or to change primary providers based on cultural preferences.

Administration

Ineligible Organizations

Wisconsin Partnership Program Protocol:

Under Federal and State law, and to safeguard the integrity of the Partnership Organization, certain people or organizations will be excluded from the Partnership Organization itself and the Partnership Organization's provider network.

Operating Guidelines:

The following entities are to be excluded from the Partnership Organization itself and the Partnership Organization's provider network:

1. Entities in which a person who is an officer, director, agent or managing employee, or a person who has direct or indirect ownership, or controls interest of 5% or more in the entity, and the person has been:

    a. Convicted of program-related crimes, patient abuse, fraud, obstruction of an investigation, offenses relating to controlled substances, or
    b. Is excluded from participation in Medicare or a State Health Care Program, or
    c. Assessed a civil monetary penalty

2. Entities that have a contractual relationship with entities listed under 1., above, and that provides one or more of the following services:

    a. Administration, management or provision of medical services
    b. Establishment of policies pertaining to the administration, management or provision of medical services
    c. Provision of operational support for the administration, management or provision of medical services

3. Entities that employ or contract with or through any individual or entity that is excluded from participation in Medicaid or Medicare for the provision of health care, utilization review, medical social work or administrative services.

Administration

Coordination with Home and Community-Based Waiver Programs

Wisconsin Partnership Program Protocol:

The Partnership Organization is responsible for coordinating referral and enrollment/disenrollment with the State's home and community-based waiver services (HCBW), Family Care and other health and/or long-term support programs in order to ensure continuity of care for people eligible for the programs.

Operating Guidelines:

1. The Partnership Organization will negotiate inter-agency agreements between the county long-term support programs and the Partnership Organization.

2. The following are required elements of the inter-agency agreements:

    a. County and Partnership Organization will work together to ensure continuity of care for people eligible for Wisconsin's long-term support programs.
    b. The Partnership Organization and the county will inform applicant's about the HCBW, PACE (where available), Family Care (where available) and the Wisconsin Partnership Program service options.
    c. The Partnership Organization and the county will share information about applicants to ensure continuity care and access to service options.
    d. People who are participating in the home and community-based waiver program who enroll in the Wisconsin Partnership Program and subsequently disenroll, will be returned to the HCBW program if the person is still eligible to do so and still desires to do so.
    e. People who are on a wait list for a HCBW program, enroll in the Wisconsin Partnership Program and subsequently disenroll from the Wisconsin Partnership Program are returned to their place on the wait list.
    f. County long-term support programs may notify Partnership members who come to the top of the county wait list that the HCBW program is an available option. The county will establish its own policies regarding how long the HCBW slot may be available.
    g. The Partnership Organization will share information about each Partnership enrollee with the county in order to establish their place on the wait list.

3. The Partnership Organization and county will develop transition protocols for people who move between the HCBW programs and Partnership. The protocols will include:

a. Each organization's role and response in an emergency, including timelines, when the person is and is not a member in the Wisconsin Partnership Program or another long-term care program.
b. Each organization's role and response when the situation is not an emergency, including timelines, when the person is and is not a member in the Wisconsin Partnership Program or another long-term care program.

Administration

Confidentiality of Information

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to keep all member information and records confidential in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other State and federal laws and regulations.

Operating Guidelines:

1. Members' protected health information ("PHI") will not be shared with anyone who is not properly authorized. This pertains to PHI gained in any manner including any verbal, written, or electronic source.

2. PHI will not be discussed, released, confirmed, interpreted, accessed, copied or distributed to any unauthorized individuals.

3. Authorized individuals include the primary and consulting physicians, and employees directly involved with member care/member information, legal guardians, government agencies as required by law, and anyone given written consent or otherwise authorized by the member. Also, any members of management staff may access PHI as it relates to the completion of their assigned duties.

4. PHI will not be discussed in public areas where it can be overheard by unauthorized individuals.

5. All requests for release of information will be referred to the Wisconsin Partnership Program Manager or his/her designee.

Administration

Record Maintenance and Availability

Wisconsin Partnership Program Protocol:

The Partnership Organizations is required by contract to have systems to maintain records in the following areas: financial, medical, grievance, and administration. The Partnership Organization is also required to protect these records from unauthorized disclosure.

Operating Guidelines:

1. Financial Records: The Partnership Organization's financial system must maintain books, records, and documents that reflect direct and indirect costs. These records include the following:

    a. Information on ownership and operation of the Partnership Organization.
    b. Financial statements for current contract year and the previous five years
    c. Federal income tax
    d. Asset acquisition, lease, sale or other action
    e. Agreements, contracts and subcontracts
    f. Franchise, marketing and management agreements
    g. Schedule of charges for the Partnership Organization's fee-for-service members (if any)
    h. Cost of operations
    i. Income, including the source and amount
    j. Cash flow statements
    k. Financial reports filed with other federal programs or authorities

2. Medical Records: The Partnership Organization must have a system for maintaining medical records for all members which includes:

    a. Safeguards against loss and unauthorized use
    b. Assurance of accuracy and accessibility
    c. Assurance of confidentiality of medical records

3. Member Complaints and Appeals: The Partnership Organization must maintain a system to record formal (written) and informal (verbal) grievances.

4. Administrative Records: The Partnership Organization must maintain a system for records that are needed for the administration of the contract with the Department and CMS.

Administration

Infection Control Plan

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to establish a written Infection Control Plan that meets OSHA regulations. The Partnership Organization is required by contract to review the plan and update the plan (as needed) at least annually, and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure.

Operating Guidelines:

The Infection Control Plan will contain at least the following elements:

1. Identify employees at risk of occupational exposure.

2. Provide for employee training or universal precautions, knowledge of risk and preventive and follow-up procedures.

3. Provide for confidential medical evaluation and follow-up following employee exposure.

4. Specify guidelines for:

    a. Record keeping
    b. Tuberculosis screening
    c. Hepatitis B vaccination

Administration

Coordination of Benefits

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to identify third party payers and coordinate benefits such that all other appropriate third party liability (TPL) payments are applied before the Partnership Organization makes payment on a claim.

Operating Guidelines:

1. Introduction

   The Partnership Organization will look to the federal regulations to determine when third party payers are primary to Medicare and Medicaid. The Partnership Organization will assume coordination of benefit (COB) functions and is subrogated to the rights of the WPP member according to federal regulation (Medicare) and Wisconsin Statute (Medicaid) with regard to third party liability (TPL) payment. This means that the rights of the member to receive direct payment by third parties for medical and long-term care are substituted with the rights of the Partnership Organization to directly collect the TPL payment. The Medicare and Medicaid capitation rates paid to the Partnership Organization Program are based on historical claims experience that is net of cost avoidance and recoveries achieved by the federal government (Medicare) and State (Medicaid) through identification of third party liability and coordination of benefits.

   The State of Wisconsin's Medicaid Program will support TPL/COB functions of the Partnership Organization in that the Department will continue to conduct insurance and Medicare enrollment tape matches and update TPL segments for all Medicaid recipients, including recipients who are enrolled in the Wisconsin Partnership Program. However, the Partnership Organization is responsible for maintaining current information on members' TPL status through member interviews conducted at enrollment and periodically thereafter and research based on the Wisconsin Medicaid on-line recipient eligibility system. The Partnership Organization is also responsible for informing the Department of any changes in members' TPL status (as indicated by the information present on the members' Medicaid identification card and the Partnership Organization's verification of new insurance information). The Partnership Organization is not required to notify the Medicare Program of changes in TPL status, but it would be good practice to do so. The Department State is not responsible for contacting the Partnership Program Organization if there are changes in a recipient's TPL status and that recipient happens to be enrolled in the Partnership Program.

2. Summary of Federal Law.

Federal law defines coordination of benefit responsibilities for both the Medicare and Medicaid programs. Managed care organizations (MCOs) that assume risk for dual-entitlees, or persons covered by Medicaid and not covered by Medicare, must take over these responsibilities: 1) identification of third party payers; and 2) coordination of benefits between Medicare, Medicaid, and any third party payers that includes identification of third party payments for services covered by the MCO. Third party, for the purpose of the Partnership Program's coordination of benefits protocol, is defined according to the CFR language as: an insurance policy, plan, or program that is primary to Medicare. Medicaid can be substituted for, or added to, Medicare. Coordination of benefits differs between the two government programs in that Medicare is sometimes the primary payer in relation to an employer group health plan whereas Medicaid would never be primary to an employer group health plan (unless the service was not covered by the plan).

In brief, Medicaid is always the payer of last resort (except in relation to Indian Health Services and certain State health insurance programs). Medicare is always primary in relation to Medicaid (except for those services that Medicare does not cover), but may be primary or secondary with relation to other third party payers. The Partnership Organization will adhere to the Medicare Program's regulation that determines when Medicare is primary to third party payers as directed in the 42 CFR.

3. The Partnership Organization will collect information on third party liability from member at enrollment. The Partnership Organization will ask questions to identify any ongoing or potential casualty, automobile accident, or workers compensation claims. The Partnership Organization will verify that information on the member's Medicaid identification card and any other insurance identification cards is accurate. The Partnership Organization will photocopy all insurance cards including the Medicare identification card.

4. The Partnership Organization will report any discrepancies between the information on the member's Medicaid identification card and what the member reports (as verified by Partnership staff with the discrepant source of third party liability) to the Medicaid Program on the TPL-17 form and to the Medicare Program's Enrollment unit. The Partnership Organization will verify both that coverage has terminated and that new coverage is active.

5. The Partnership Organization will adhere to the Medicare Program's regulations, as specified in the CFR at 411.20-411.206, on coordination of benefits with respect to which insurance program is the primary and secondary (or tertiary) payer for dual entitled members and the Medicaid Program's regulations for members who do not have Medicare as outlined in the Medicaid Part A, All Provider Handbook.

6. The Partnership Organization will have specific primary and secondary payment guidelines that are initially consistent with current Medicaid and Medicare policy. However, the goal is to have consistent guidelines between Medicaid and Medicare. These guidelines will be included in the Contractor Manual. The Partnership Program claims processing system will be driven by specifications based on coordination of benefits policies and appropriate provider/vendor reimbursement methodologies. The Partnership Program will make secondary payment methodologies explicit in its sub-contract negotiations with service providers and vendors.

   The Partnership Program will establish a tracking system to record payments from third party liability.

7. The Partnership Organization will handle potential and ongoing cases involving automobile insurance, casualty insurance, and workers compensation, and shall either assist members with filing claims related to accidents or guide members to appropriate resources. The Partnership Organization will adhere to the Medicare Program's regulations on coordination of benefits with these insurances for dually-entitled members and the Medicaid Program's regulations for members who do not have Medicare.

Administration

Data Collection and Reporting

Wisconsin Partnership Program Protocol:

The Partnership Organization is required by contract to regularly report accurate program information to the Department and CMS. In addition to any rights set forth in the contract to obtain, review, assure the reliability of the data, and assure the completeness of data, the Department and CMS may also have rights set forth in statute and regulation to obtain provider data for purposes of program monitoring.

Operating Guidelines:

1. Periodic Reports in General

    a. An overview of the reporting schedule is included in the table attached to the Contract between the Partnership Organization and the Department.
    b. The Partnership Organization is required by contract to provide reports to the Department contract monitor in the Center for Delivery Systems Development (CDSD) at the address indicated in the contract.
    c. The Partnership Organization will comply with reasonable requests from the CDSD so that data uniformity can be maintained across all Partnership Organizations.
    d. The Department may provide the Partnership Organization with training in the use of data collection tools and may conduct ongoing monitoring to determine data completeness and reliability.
    e. The Partnership Organization is required by contract to regularly collect and report the following standardized information:

2. Encounter Data

    a. Member-specific intake, enrollment, and event encounter data will be coded and reported in accord with the Utilization Reporting Documentation User Manual to be developed and maintained by the Department.
    b. Encounter data collection definitions and methods may change to meet additional CMS and Department reporting requirements, or in response to requests from the Partnership Organization.
    c. The Department will notify Partnership Organization of changes in reporting requirements at least three months in advance of the due date for affected reports.
    d. The Department may provide the Partnership Organization with training in the use of data collection tools and my conduct ongoing monitoring to determine data completeness and reliability.

3. Intake

    a. The Intake File will include a record for each person who participated in the intake process during the reporting period, whether or not the intake process was initiated before or completed after the period.
    b. The Intake File will include information for each potential member with whom the Partnership Organization staff held a face-to-face discussion of Partnership as a care option.
    c. The Partnership Organization is not required by contract to report the names of people who only request information.
    d. The Enrollment File will include a record for each person who was enrolled in the Partnership Program for any part of the reporting period.
    e. The Event File will include a record of each occurrence of the fifty-one reportable events listed for any person who was enrolled in Partnership during any part of the reporting period. Each record in the event file will include the individual member's Medicaid ID number, as well as a date or dates and units as appropriate.

4. Financial Reports

    a. Financial information will be collected and reported in accord with the Partnership Financial Management and Reporting technical assistance document.
    b. Financial reports will include budgeted versus actual expenditure for the current reporting period and year-to-date, based on cost-center accounting methods.
    c. Frequency: In the first year of operation, reports will be submitted on a monthly basis and due within 45 days after the end of each month. Thereafter, reports will be submitted on a quarterly basis with reports due 45 days after the close of each quarter. The Department reserves the right to extend the monthly submission requirement beyond the first year should contractor performance indicate a need for further monitoring.

5. Semiannual Narrative Reports should describe:

    a. Accomplishments
    b. Utilization Management
    c. Staff Development
    d. Marketing
    e. Special Studies conducted, if any
    f. Barriers and Solutions
    g. Plans for the next period

6. Complaints and Appeals. The Partnership Organization will report quarterly on all complaints and appeals. This information should include the name of the member, date of the written complaint or appeal, brief statement of the nature of the

complaint or appeal, whether the member requested an expedited review and the outcome.

7. Third Party Liability. The Department will provide the Partnership Organizaiton with a set of forms to the Partnership Organization to collect information for the Third Party Liability Report.

8. Federally Qualified Health Centers. The Department will provide the Partnership Organization with a set of forms to collect information for the Federally Qualified Health Centers Report.

9. AIDS and Ventilator Dependent Members. The Department will provide the Partnership Organization with a set of forms to collect information for the AIDS and Ventilator Dependent Members Report.

10. Sterilizations and Hysterectomies. The Department will provide the Partnership Organization with a set of forms to collect information for the Report of Sterilizations and Hysterectomies, if any have occurred.

11. Insurance Commission. The Partnership Organization will provide the Department with copies of reports the Partnership Organization submits to the Office of the Commissioner of Insurance.

12. Personal Injury Settlements. The Department will provide the Partnership Organization with forms to report information regarding Personal Injury Settlements. When Wisconsin Partnership Organizations are aware of personal injury case settlements, Wisconsin Partnership Organizations will submit any information regarding such settlement to the Department as soon as practical.

13. Annual Audit.

    a. The Partnership Organization is required by contract to provide the results of an audit, including "Letters to Management", for the prior calendar year, by July 1 of the Medicaid Contract year, performed by an independent certified public accountant.
    b. Financial statements shall be presented in a form specified by the Department that clearly shows the financial position of Wisconsin Partnership Organizations in each enrollment area.
    c. The Partnership Organization is required by contract to provide to the Department as part of this audit and also by July 1 of the Medicaid Contract year, either:
        i. As a part of the annual audit, a clear indication of total costs, direct and indirect, related to enrollees; or
        ii. Estimates based upon generally accepted accounting principles and supporting work papers of those total costs.

d. The Partnership Organizations will authorize the independent accountant to allow representatives of the Department, upon written request, to verify the audit report.
e. Access to and Audit of Contract Records
    i. Throughout the duration of the Medicaid Contract, and for a period of six (6) years after termination of the Contract for Medicaid Services, the Partnership Organization will provide duly authorized representatives of the State or Federal government access to all records and material relating to the Contractor's provision of and reimbursement for activities contemplated under the Medicaid Contract.
    ii. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of the Medicaid Contract.
    iii. All information so obtained will be accorded confidential treatment as provided under applicable law.

14. Records Retention.

a. The Partnership Organization shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Medicaid Contract, including claim forms, for a period of not less than six(6) years from the date of termination of the Contract.
b. Records involving matters which are the subject of litigation shall be retained for a period of not less than six (6) years following the termination of litigation.
c. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of the Department, provided that the microfilming procedures are approved by the Department as reliable and are supported by an effective retrieval system.
d. Upon expiration of the six (6) year retention period, the subject records shall, upon request, be transferred to the Department's possession.
e. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

15. Special Reporting and Compliance Requirements. Wisconsin Partnership Organizations shall comply with the following State and Federal reporting and compliance requirements for the services listed below:

a. Hysterectomies and sterilizations shall comply with 42 CFR 441 Subpart F—
b. Sterilizations.

Administration

Solvency and Member Protection

Wisconsin Partnership Program Protocol:

The Partnership Organization must maintain fiscally sound operations to prevent insolvency. The Partnership Organization must have a written insolvency protection plan that includes administrative procedures for: 1) establishing and maintaining a risk reserve; 2) member protection in the event of insolvency.

Operating Guidelines:

1. Risk Reserve

The Partnership Organizations will maintain a Risk Reserve as required by Article XIV of the Medicaid contract.

2. Member Protection

   a. Members will not be liable for Partnership Organization debts if the Partnership Organization becomes insolvent.
   b. If the Partnership Organization should become insolvent, the Partnership Organization's members will be disenrolled from the Wisconsin Partnership Program and return to Medicaid and/or Medicare fee-for-service, or other programs for which they may be eligible.

Administration

Office of the Commissioner of Insurance

Wisconsin Partnership Program Protocol:

The Wisconsin Partnership Program operates on a risk-capitated basis. Therefore, the Partnership Organization is subject to the insurance requirements of the Wisconsin State Statutes, Chapter 600 to 647 unless the Office of the Commissioner of Insurance grants the Partnership Organization an exemption order.

Operating Guidelines:

1. The Partnership Organization and the Department of Health and Family Services will jointly petition the Office of the Commissioner of Insurance for an exemption order from Wisconsin Insurance Statutes Chapters 600 to 647 for the Partnership Program.

2. OCI has granted the Partnership Organization an exemption order for the Wisconsin Partnership Program. The exemption order was granted on a time-limited basis, due to the demonstration nature of the program. An extension to the exemption order will be requested jointly by the Partnership Organization and Department of Health and Family Services

3. The exemption order may include financial and enrollment reporting requirements to OCI. The Partnership Organization's exemption order may require the Partnership Organization report, within 180 days of the end of the organization's fiscal year, the following information to OCI:

    a. Balance sheet showing assets and liabilities
    b. Statement of revenues and expenses
    c. Enrollment table showing total enrollees by quarters

Administration

Audits

Wisconsin Partnership Program Protocol:

CMS and the Department have the authority under statutes and regulation to inspect and/or audit the Partnership Organization (and its subcontractors).

Operating Guidelines:

1. During contract life and six years after the contract, CMS and the Department may inspect and/or audit the Partnership Organization in the following contract related areas:

    a. Financial
    b. Medical (documentation, records)
    c. Program (utilization, enrollment, services, grievance, subcontracts, MOUs)
    d. Other as determined by the Department and/or CMS

2. The Partnership Organization has the right to review, and comment on, any studies r audits that are going to be released to the public.

Administration

Sanctions

Wisconsin Partnership Program Protocol:

CMS and the Department have the authority to deny payments and impose sanctions for violations identified in the federal law.

Operating Guidelines:

CMS and the Department may pursue sanctions and remedial actions for any of the following:

a. Failure to provide medically necessary services required under the Medicaid Contract.
b. Require members to pay amounts in excess of premiums permitted.
c. Engage in any practice that discriminates among individuals on the basis of their health status or requirements for health care services.
d. Engage in any practice that could reasonably be expected to have the effect of denying or discouraging enrollment by eligible individuals whose medical conditions or histories indicate a need for substantial future medical services.
e. Misrepresent or falsify information that is furnished to CMS or the Medicaid Agency.
f. Failure to promptly pay claims.
g. Contract or employ any individual or organization that currently is excluded from participation in Medicare and/or Medicaid.